HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY

ON

MRS. KYERAA BENEDICTA

BY

MISS PRADE ANITA

4122190096

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

(DIPLOMA).

AUGUST, 2022

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PREFACE

The family centered maternity care is a systematic approach used in nursing an expectant mother and her family through pregnancy, labour and puerperium. This is based on a thoughtful understanding of the client as an individual with specific problems and needs that should be addressed. The aim of this care study is to ensure that, the pregnancy results in a healthy mother, baby and a family. During this period of care, the physical, psychological, spiritual and social well-being of the client and family are taking into consideration.

The family centered maternal care study is an academic work which gives the student midwife an opportunity to nurse her client using the nursing process plan and the partograph to implement and evaluate her pregnancy, labour and puerperium using the knowledge and skills acquired during the training.

The report on the care study is compiled into a document which is part of the Nursing and Midwifery Council of Ghana’s fulfilment in awarding professional certificate to the student midwife as a registered midwife after three years training.

ACKNOWLEDGEMENT

From the innermost part of my heart, I express my sincere gratitude to the Almighty God for the life, opportunities, knowledge, wisdom, understanding and strength throughout the training and more especially writing of this care study.

Sincerest appreciation is to the entire tutorial staff and non-teaching staff of Holy Family Nursing and Midwifery Training College, Berekum and more especially to the Principal, Ms. Monica Nkrumah, my supervisor, for her support, encouragement and guidance towards the successful completion of this care study.

I wish to express my profound gratitude to Madam Kyeraa Benedicta the client and her family members for their consent, contribution and co-operation throughout the period and to a successful completion of the care study.

My deepest appreciation goes to the entire staff of Adabokrom Health Centre at Adabokrom in the Western North Region and especially the midwife in-charge, Ms. Mercy Coffie and the entire staff, for their support.

Furthermore, abundant thanks to all my beloved family members more especially my father Mr. Appiah Joseph , my mother Mrs. Esaah Veronica who endlessly helped me throughout my training in physical, financial and spiritual well-being. I say ayekoo.

Finally, my sincere thanks to the authors of the various books used as references and from which I took inspiration for this care study.

INTRODUCTION

The family centered maternity care study is a study about the nursing care given to the expectant mother, her unborn baby and her family as well. The student midwife puts into practice knowledge acquired in the classroom to care for the pregnant woman and her family in solving any identified problem in the course of the interaction throughout pregnancy, labor and puerperium.

This study was conducted on Madam Kyeraa Benedicta, a 21 years old gravida 2 Para 1 alive. She is from Berekum Ayimo in the Bono Region of Ghana but currently staying at Adabokrom. She was met on the 1st November, 2021 at Adabokrom health Centre with 37 weeks+5days gestation and had come for her 8th antenatal care.

The study is in four (4) chapters beginning from pregnancy to puerperium. Chapter one talks about the client's general background including her social, medical, surgical, menstrual, past and present obstetric histories. It continues with chapter two which gives a detailed of how the study was conducted during the period of her pregnancy. Chapter three is on labor till, the end of the first six hours after delivery thus puerperium chapter four. Each chapter ends with a care plan drawn for her with the problems which were identified throughout the period, this constitutes the appendices.

LITERATURE REVIEW

PREGNANCY

It is a period of having a developing embryo in the uterus and it is a time when women and their partners are especially open to reflecting on their lifestyles and healthcare options.

Myles (2009) states that as soon as pregnancy is confirmed, many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of hormones namely estrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing fetus since the fetus depends solely on the mother for survival in utero. variety of care that are rendered to the expectant mothers and their entire families which includes history taking, physical examination (head to toe examination and abdominal examination. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, fersolate and multivitamin), and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet, travelling, rest and sleep, exercise, personal and environment hygiene, birth preparedness and complication readiness.

Fraser & Cooper (2009), states that, all changes in the mother's body during pregnancy are due to the effects of specific hormones. These changes enable her to nurture the foetus, prepare her body for labor and develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Psychological state is also affected by hormonal changes. The gestational period is divided into three Trimesters. The first trimester is from the time of conception to the 12th week. The second trimester is from the 13th week to the 24th week whilst the third

trimester is from the 25th week to the 38thweek of pregnancy antenatal care is given to the woman throughout the period and should commence from the time pregnancy is diagnosed and continue until the safe delivery of the baby.

Tiran (2008) pregnancy is the condition of having a developing embryo or fetus within the body from conception to the delivery of the fetus. The normal duration is about two hundred and eighty (280) days, forty (40) week or nine (9) months seven (7) days counted from the first day of the last normal menstrual period to delivery. Physiological and psychological changes occur due to the effect of estrogen and progesterone which provide nutritive and protective environment for the developing embryo and also prepares the breast for lactation.

(King,2014) pregnancy is a time of profound anatomic and physiologic changes in a woman's body. Maternal physiologic systems make adaptations needed to support the developing foetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty-six days (266) or thirty-eight weeks (38) from ovulation. The antenatal period is into trimesters, first trimester is considered to be weeks 1 to 12 (12weeks) because organogenesis is completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 weeks was limit of viability. The third trimester extend from 29 to 40 weeks. The term 'post-date' or post term is typically used to describe a pregnancy beyond forty weeks (40).

(Weller B.F, 2009) states that, pregnancy is a state of being with a foetus from the time of conception to the expulsion of the foetus. The normal period is 280 days or 40 weeks counted from the last day of the normal menstrual period. Pregnancy is divided into three trimesters, a period of

three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second trimester begins from the 13th week to the 24th week of pregnancy. The third trimester starts from the 25th week to the 40th week. Physiological changes occur in the body under the influence of hormones which affect all the systems and organs with the greatest change taking place in the uterus as it has to accommodate and nourish the developing fetus, prepare the woman body for labor, develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. Any disorder due to the physiological changes is managed to prevent complications such as anemia which can endanger the life of both the mother and growing fetus.

Ojo and Briggs (2011) states that when pregnancy occurs, menstruation ceases for some weeks or months after delivery. Most women experience some minor disorders such as morning sickness, nausea, frequency of micturition, heart burns among others. Such conditions may not be life threating but can be harmful: the women therefore need to be educated on these conditions so that they can understand and cope with their occurrence. Antenatal care is the advice, supervision and attention a pregnant woman receives to ensure good health as well as early detection and treatment of complications which may affect the woman or her baby.

LABOUR

Konar (2011) states that, labor is a series of event that takes place in the genital organ in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. Onset of labor is very much unpredictable to foretell precisely the exact date of onset of labor. It not only varies from case but even in different pregnancies of the same individual. Conventionally

events of labor are divided into four stages: First stage starts from the onset of true labor pains and ends with full dilatation of the cervix. average duration is twelve hours (12) in primigravida and six hours (6) in multipara. Second stage starts from the full dilatation of the cervix (not from the rupture of the membranes) and ends with expulsion of the fetus from the birth canal. It has got two (2) phases thus the propulsive phase starts from full dilatation up to the descent of the presenting part to the pelvic floor and the expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. Its average duration is two hours (2) in primigravida and thirty minutes (30) in multipara. Third stage begins after expulsion of the fetus and ends with expulsion of the placenta and membranes (after-births) and control of hemorrhage. Its average duration is about fifteen minute (15) in both prim gravida and multipara. The duration is, however, reduced to five minutes (5) in active management. Fourth stage is the stage of observation for at least one hour (1) after expulsion of the after-births. General condition of the patient and the behavior of the uterus are to be carefully monitored. Under bladder care, patient is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the woman cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the patent fails to pass urine especially in late first stage, catheterization is to be done with strict aseptic precautions. Rest and ambulation; if the membranes are intact, the patient is allowed to walk about. This attitude prevents venacava compression and encourages descent of the head. Ambulation can reduce the duration of labor, need of analgesia and improves maternal comfort. Labor is monitored electronically or analgesic drug (epidural analgesia) is given, she should be in be. The transition from the first stage to the second stage is evidenced by the following feature Increasing intensity of uterine contractions, urge to defecate with descent of the presenting part, Complete dilatation of the cervix on vaginal examination.

Varneys (2014) describes the onset of labor as the occurrence of regular painful contractions that promote dilatation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration, and intensity are hallmark of labor. There are four stages of labor that has being established; the first, second, third and fourth stages. The first stage of labor starts with cervical dilatation which begins with regular rhythmic uterine contractions until the cervix is fully dilated. During this stage enquiry is to be made about the onset of labor pains or leakage of liquor if any through general and obstetrical examinations including vaginal examination are to be carried out and recorded. Records of antenatal visits, investigation reports and any specific treatment given if available are to be reviewed. There is an assessment of progress of labor and partograph recording. The second stage of labor begins with the expulsion of the fetus from the birth canal, it starts when the cervix is fully dilated and the woman has the urge to expel the fetus and ends when the fetus is born. The third stage of labor is the complete expulsion of the placenta and its membranes as well as the arrest of hemorrhage. The fourth stage of labor is 6 hours after the delivery of the placenta and membranes and continues with close monitoring of the client and baby.

Myles (2014) states that, labor purely in physical sense, may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Labor has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in primigravidae. This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labor is the expulsion of the fetus. Cervix is fully dilated

and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labor completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of fetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labor and it last six hours after delivery of the placenta.

The National Safe Motherhood Service Protocol (2008) states that normal labor begins with a regular painful uterine contractions lasting at least twenty (20) seconds (timed by a trained observer) occurring at a frequency of at least two contractions in every ten minutes and with cervical dilatation of at least 3 centimeters. Signs that women may experience prior to labor includes show (pink mucous discharge from the vagina), engagement of the baby's head. The hormone oxytocin is responsible for the strong regular contractions of labor which when released cause the uterus to contract. Labor contractions feel very different from Braxton Hicks contractions that women experience during pregnancy but the most important difference is that labor contractions come regularly. Each one starts gradually, builds up to a peak and then fades away. Typically, when labor begins, contractions are short in length around 20 – 30 seconds long. As labor progresses contractions become gradually longer and stronger which dilates the cervix.

Tiran (2008) defined labor as the process by which product of conception are expelled from the uterus through the birth canal. Labor normally occurs spontaneously at term, that is between 38 and 42 weeks of pregnancy. The fetus should present with vertex and once started, the contractions should increase in strength and frequency without interruption and artificial stimulation until fetus, placenta and membranes are expelled by the maternal effort through the vagina. partograph is the graphical recording of labor progress obtained by assessment of visual patterns of cervical

dilatation and descent of the presenting part in conjunction with records of maternal and fetal wellbeing.

PUERPUERIUM

National Safe Motherhood Service Protocol (2008) postnatal period is the period that starts from the end of delivery of the placenta and membranes and control of hemorrhage to six weeks after delivery. The purpose of postnatal care is to maintain the physical and psychological wellbeing of the mother and child. Postnatal care includes education of the mother on the care of her baby, detection and treatment or referral of any abnormalities for further management. The essential components of postnatal care are therefore: Comprehensive screening to detect complications in both mother and baby, Treatment of complications in mother and baby, Assessment and support for infant feeding, Malaria and anemia prevention. Some common discomforts of postpartum period in mothers listed are after pains, perineal pain, bowel and urinary changes, stretch marks, fatigue, sleeplessness, backache, headache, hemorrhoids and mood changes in the two weeks. Those associated with the newborn are caput succedaneum, tongue tie, rashes and vomiting after feeds. The major causes of death in this period are infections, hypertensive complications, hemorrhage and thromboembolism of which predisposing factors include: Conditions or complications during the antenatal period, Complications of labor, related to duration of labor and mode of delivery

Myles (2008) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. Puerperium starts immediately after the delivery of the placenta and membranes and continues for six weeks. The overall expectation

is that by six weeks after the birth of the baby, all the body systems will have recovered from the effects of pregnancy and return to their non-pregnant state. Between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long term health.

Konar (2011 puerperium is the period following childbirth during which the body tissues, specifically the pelvic organs reverse back approximately to the pre-pregnant state both anatomically and physiologically. This begins as soon as the placenta is expelled and last for approximately six weeks when the uterus becomes regressed to the non-pregnant size called involution, the period is arbitrarily divided into(a) immediate-within 24 hours;(b) early-up to 7 days and remote up to 7days. In its anatomical consideration, the uterus immediately following delivery becomes firm and retract with alternate hardening and softening. The uterus measures about 20×12×7.5 centimeters (length, breadth and thickness) and weighs about 1000grams. At the end of six weeks, its measurement is almost similar to that of the non-pregnant state and weighs about sixty (60) grams. The physiological consideration of involution is most marked in the body of the uterus where the changes occur in the muscles, blood vessels and endometrium.

Ojo & Briggs (2011) defined puerperium as a period that starts
after the delivery of the placenta and ends when the uterus return to its pre pregnant state. The first ten day of puerperium is term as the lying –in period where close observation of both mother and baby are considered. During this period, bonding is fostered through the establishment of breastfeeding. The puerperal woman regains her strength that was lost during labor. Care of the baby and lactation are established during this period. The management which the mother and baby

required during puerperium is based on three principles; Promoting physical and psychological well-being of mother and baby, encourage good infant feeding and maternal to child relationship, supporting and strengthening the mother's confidence to enable her to fulfil her mothering role within her family and culture status.

WHY I CHOSE MY CLIENT

Madam Benedicta G2 P1 reported to the antenatal clinic on the 1st November, 2022 at Adabokrom Health Center at 9:00am and was her eight antenatal visit. The client was 37 weeks + 5days pregnant. During the visit she complained of waist pains and constipation. Client explained her previous pregnancy was not like that and so she was worried about it. It was observed that client

had minimal knowledge on the minor disorders of pregnancy. Client was advised that each and every pregnancy is unique and different and it was minor disorder of pregnancy which will resolve after delivery. The physiology of constipation and waist pains was then explained to her. The midwife incharge was informed about intention to use Madam Benedicta for the care study which permission was granted. Care study and what it entailed was explain to Madam Benedicta and she readily agreed to be used and promised to give all she could to help throughout the care study. She was assured of confidentiality and quality healthcare. Client gave out direction to her house and phone number to help make visits to her house easier.

CHAPTER ONE

CLIENT'S PARTICULARS

INTRODUCTION

This chapter gives the overview of information about Madam Benedicta, her family and the community in which she lives which comprises the social, surgical, family, past obstetrical and present obstetrical, Menstrual history and hobby etc. This information helps the student Midwife to provide holistic care for the client and her family taking into consideration the physical, psychological and spiritual needs.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Benedicta a 21yr old lady who was born on the 1st October, 1999 who comes from Berekum Ayimo in the Bono Region but is currently staying with her husband in Adabokrom in the Western-North region. She is fair in complexion, 159cm in height and weighs 51.3 in kilograms at booking. Madam Benedicta and husband are both devoted Christians. According to Madam Benedicta, she had her education up to junior high school level at Adabokrom in the Western North but could not continue due to financial difficulties. Client is married to Mr. Baah Isaac, who is also a mechanic, 27yrs of age, 175cm tall, dark in complexion and was born at Berekum Ayimo in the Bono Region but resides at Adabokrom. He can speak English and Twi while his wife speaks only Twi , Madam Benedicta has 5yr old daughter named Pomaa Anabel whom she said is her next of kin and is receiving education in Adabokrom. Client verbalized that her husband is supportive and they live happily together.

1.2 FAMILY HISTORY

Opanin Joseph Amankona and Madam Janet Kyeremaa are the parents of Madam Benedicta. Both parents are alive and residing at Adabokrom. Her mother is farmer and her father also a farmer as their occupation. The client is the fourth among 9 siblings which 4 are females and 5 are males. According to her, there are no hereditary medical conditions such as diabetes, sickle cell disease, mental disorder, epilepsy,and Asthma in her family. She further stated that there has been no history of multiple pregnancies in her family and that of her husband's family .

1.3 MEDICAL HISTORY

According to the client, she has never been admitted to a hospital before and also affirmed that she sometimes experienced minor illnesses of which required medical so upon few occasions has

ended up at the outpatient's department of the Adabokrom health Center. She also made claims that usually she experiences malaria per diagnosis. She has no known allergies to food and drugs and also, has no medication for chronic illness.

1.4 SURGICAL HISTORY

Madam Benedicta claimed she has never had a road-traffic accident that has affected her pelvis and any part of her body before. She has neither undergone any surgical operation that has affected her pelvis, spine nor reproductive organs. Also, she has never received blood transfusion or donated blood before.

1.5 MENSTRUAL HISTORY

According to Madam Benedicta, she had her menarche at the age of 15yrs while in the junior high school. She has a 28-day menstrual cycle bleeding during menstruations and occur 5 days each month with no sign of dysmenorrhea. She makes use of two sanitary pads daily to guide her flow and changes after when necessary. She did not recalled her last menstrual period which led to her pregnancy.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Benedicta goes to bed usually around 7:30pm and gets out of bed at 6am the next day. She visits the bathhouse to urinate and empty her bowels at least twice a day. After which she washes her face and brushes her teeth with tooth brush and tooth paste. The next thing she does is to sweep her compound and empty her refuse dump when is full, bath her daughter after which she prepares

breakfast and she takes it together with her husband and their daughter before send her to school. She continues with her house chores, that is washing their dirty clothes and the utensils been used. After all these, she takes her bath, put on her farm clothes and joins her parents at the farm just some minutes away from their house. Around 12pm she comes back home and take something for her lunch and call her husband to come and eat.Then she take her rest until 4pm she starts preparing her evening meal for her husband and daughter. By 5:30pm supper will be ready by then her husband and daughter will be back home of which she serves him and feed her daughter she goes to take her bath and bath her daughter, after which she eats hers. She eats three times a day. She neither smokes cigarettes nor takes any alcoholic drink. On Saturdays, madam Benedicta cleans the house. Her dirty clothes as well as that of her husband and daughter are washed and dried in the sun. Madam Benedicta favorite food is Banku and okro stew and always enjoys conversing and listening to music but uses her leisure time mostly to sleep. On Sundays, she goes to church with her husband and daughter and closes around 12pm, comes back home and prepares lunch for the family.

1.7 PAST OBSTETRIC HISTORY

Pregnancy: Madam Benedicta, gravida 2 Para 1, alive, went through her pregnancy without any ill-health and had term pregnancy. There were no complications like Ante Partum Hemorrhage, Pregnancy Induced Hypertension, Hyperemesis Gravidarum and Abortion . She said she had two doses of tetanol toxoid injections (On her first antenatal visit and four weeks after first injection was given) throughout her pregnancy and had five doses of Sulphadoxine-pyrimethamine as prophylaxis against malaria. Between her first born and her current pregnancy is five years. She was a regular attendant to antenatal care till she delivered.

Labour: She had spontaneous vaginal delivery to an alive female infant at Essam Government Hospital in Essam. Her baby cried as soon as she was delivered with birth weight of 2.9 kilograms and the labour lasted for 11 hours. The third stage was actively and properly managed without any complications. In the fourth stage, the condition of the mother and the baby were good. Blood loss was moderate but she could not specify. She said she experienced lower abdominal pains after delivery which subsided the next day.

Puerperium: Madam Benedicta puerperal period, according to her was also normal. She had no puerperal psychosis. Her baby suckled her breast soon after she delivered hence lactation was established Client visited the postnatal clinic frequently. She and her baby were healthy throughout. She practiced exclusive breastfeeding for six months for her baby and combined complementary feed like corn dough porridge, well mashed food and cerelac while she continued the breastfeed. According to Madam Benedicta, her daughter received the immunization against childhood preventable diseases. She also said she received support from her husband and mother during previous delivery. She weaned off the breast at two years. Her daughter was healthy till two years when she started to experience symptoms like fever and diarrhea but treated at O.P.D. Madam Benedicta said used artificial family planning to space her birth like the Depo.

1.8 PRESENT OBSTETRIC HISTORY

Madam Benedicta visited the antenatal clinic when she was 17+5 weeks pregnant on 10th June, 2021 at Adabokrom Health Center. According to Madam Benedicta antenatal card, her last menstral period was 10th Febuary 2021and the estimated date of delivery was 17th November 2021 whiles her first ultrasound scan estimated date of delivery was 17th November,2021 and second ultrasound scan was done on October 26th ,2021 and the EDD was 28th November 2021.

On Madam Benedicta first antenatal clinic visit, her history was taken and recorded which included personal, family, medical, surgical and obstetrical histories. Laboratory investigations were also taken and physical assessment was done and recorded. Results of investigations which were carried out were as follows;

Hemoglobin Level	-	11. 6g / dl
Sickling Test	-	Negative
Blood group	-	AB
Rhesus factor	-	Positive
G6PD	-	No Defect
Syphilis(VDRL)	-	Negative
HIV status	-	Negative
Urine R/E	-	Negative
Stool R/E	-	No abnormalities detected

The following observations were made and recorded;

Temperature	-	$36.3^{O}{}_{C}$
Pulse	-	84bpm
Respiration	-	20cpm
Blood Pressure	-	105/69mmHg

Hepatitis B Status - Negative

Other measurements were taken as follows:

Weight - 51.9kg

Height - 159.cm

Records on Madam Benedicta antenatal card indicated that she was examined from head to toe and no abnormalities were detected. She was educated on danger signs in pregnancy and was also given treated insecticide net to sleep under to prevent malaria in pregnancy. She said she has no complains, therefore she was served with the following routine drugs;

Tablet Folic acid 5mg (1 daily) for 30 days

Tablet Fersolate 200mg (1daily) for 30 days.

Tablet Multivite 200mg (1 daily) for 30 day

She was scheduled for the next visit, which she followed correctly and carried out all the laboratory investigations requested until she was met on the 1st November,2021 when she was 37+5 weeks pregnant

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter gives a brief insight of the care given to Madam Benedicta during pregnancy specifically from the 37+5weeks. It lays more emphasis on the first contact with client, various home visits and subsequent visits and also the nursing care plans drawn to solve her problems during pregnancy.

2.1FIRST CONTACT WITH THE CLIENT

Madam Benedicta was met on 1st November, 2021 at Adabokrom Health Center during the antenatal day when she was 37+5weeks pregnant. It was her eighth visit to the hospital. This woman was approachable, and ready to share any information when given the mandate. Introduction was made as Prade Anita, a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, sent to Adabokrom Health Centre on eight weeks clinicals to have a practical experience in midwifery. Her antenatal book was collected and found out that she fall within the criteria and she have being attending antenatal clinic regularly and have no abnormal condition which can be a threat to her pregnancy but complained she had waist pains and constipation, and which her previous pregnancy was not like that so decision to use her for the client /family centered maternity care study has made in order to educate her on how to cope with the minor disorders which was made. A brief information was given to her about the care study and why she was chosen and she readily accepted it and pledged her full support and cooperation. She was then taken through the general examination when it got to her turn with procedure explained. She was encouraged to ask questions. Her vital signs were checked and recorded as follows;

Temperature - $36.6^{O}C$

Pulse - 80bpm

Respiratory rate - 20cpm

Blood pressure - 110/60mmHg

Other observations made were recorded as follows;

Weight - 57.6kg

Urine tested for protein and glucose were negative.

After the above procedures, education was offered to her on the following; warning signs in pregnancy like bleeding per vaginum, oedema and losing of liquor layette, signs of impending labour, taking of medication as prescribed and avoidance of drug abuse, sleeping under an insecticide net to prevent malaria and good nutrition.

Physical Examination

Client's permission was sought to perform physical examination from head to toe and the procedure was explained to her. She was asked to empty her bladder, privacy was ensured and was helped to undress, assisted to lie on the examination couch and covered with a clean cloth. Hands were washed with soap and water and dried with clean dry towel. Client was examined from head to toe, under supervision of the midwife in charge; no abnormality was detected.

Client's hair was examined and it was neatly combed with no dandruff or lice. The sclera and conjunctiva were normal with no yellowish discoloration. There were no discharge from the nose and ears. The mouth, tongue and teeth were clean. On neck palpation, no lymph nodes were found.

The breast has no lumps, dimples or discharge during palpation. Client was taught how to do self-breast examination and she was educated to examine her breast regularly for early detection and

reporting of any abnormalities. The hands and fingers were inspected and the nails were short and neat. The lower extremities were examined and no abnormalities like swelling was seen. The back was also inspected for oedema at the sacral region and the condition of the skin. There was no oedema at the areas inspected and the condition of the skin was good.

Abdominal Examination

Before abdominal examination, palms were rubbed together to provide warmth to prevent induced contractions.

Inspection; the abdomen was inspected for scars, linea nigra and striae gravidarum and none of these were detected. The size and shape were globular and medium respectively with some foetal movements.

Measuring Of Symphysio-Fundal Height; To measure the symphysio fundal height the hands were warmed by rubbing palms together before the upper border of the symphysis pubis and the uterine fundus were located .The zero end of the measuring tape was placed on the upper border of the symphysis pubis and the tape extended to the fundus of the uterus and the symphysio-fundal height measured 33 centimetres and gestational age of 37+5weeks .

Fundal Palpation; upon facing the head of the woman on her right hand side, the fundus was palpated with both palms and a smooth surface was felt indicating the foetal buttocks.

Lateral Palpation; with one hand stabilizing the right side of the maternal uterus, the other hand was moved gently on the left side where rough parts were felt indicating the foetal limbs as palpated. This was repeated at the right side and a smooth round part was observe indicating the

foetal back and this will also help to locate the position of the foetus to help listen to the foetal heart sounds using the fethoscope.

Pelvic Examination; facing the woman's lower limbs and placing the palms of both hands on either side of the lower abdomen below the umbilicus pointing downwards and inwards a hard mass was felt and the fetal head was palpated.The lie therefore was longitudinal, presentation was cephalic and the position was right occipito-anterior.

Descent; the anterior shoulder was located and five fingers were admitted between the shoulder and the symphysis pubis indicating $5/5^{th}$ above the pelvic brim.

Auscultation; A fethoscope was warmed by rubbing in between the palms and placed at the back of the foetus to listen to the foetal heart sounds for one minute noting the volume and rhythm whiles comparing it with the maternal pulse to ensure that it was not maternal radial pulse being listened to; foetal heart beat was 133 beats per minutes. Fetal movements were noticed after auscultation and woman was asked if she feels any foetal movements and any change.

Vulva Examination; Permission was sought to examine the vulva and it was granted of which she was helped to assume a lithotomy position. Hands were washed under running water with soap and dried with a clean towel and examination gloves were put on. The mons pubis was well shaved; there were no scars, oedema, varicose veins and genital warts, the labia , clitoris and perineum were also inspected for cleanliness, size ,shape ,redness ,tenderness ,rashes ,signs of trauma ,sores ,bleeding and abnormal discharges of which no abnormalities were detected . Also, there was evidence of good vulva hygiene so she was applauded for the good work done and was asked to continue with it. She was however educated against the wearing of nylon panties but instead use cotton panties. She was also educated about douching. The client was asked to lie laterally and sit

up before getting out of the couch. She was congratulated for allowing the procedure to be done on her. Hands were washed and dried and all findings were explained to her and recorded in her antenatal book.

She complained of pains in the lower abdomen which she thought would affect the baby during delivery and puerperium. She was reassured and educated that it was due to the pregnancy since the fetus is engaging into the pelvis thereby exerting pressure on other organs and nerves in the sacral region. She also complained of waist pain and her waist pain was explained to her that it was due to relaxation of the joints of the pelvic bone by pregnancy hormone and she was reassured to bend from kneel and also rest in between activities. She was thanked for her cooperation. The stages and true signs of labour were explained to her. That was; first, second, third and fourth stages also show, painful rhythmic uterine contractions respectively. Madam Benedicta was educated to report to the clinic if she sees any.

She was served with routine drugs as below;

- Tab Fersolate 200mg daily for 7 days
- Tab Multivitamin 200mg daily for 7 days
- Tab Folic acid 5mg daily for 7 days

She gave direction to her house and phone numbers were exchanged. Client having agreed to be used for the study, arrangement was made to visit her house on 6th November,2021 . She was thanked and was escorted to the entrance of the hospital.

2.2 FIRST ANTENATAL HOME VISITS

First home visit to Madam Benedicta was on the 6th November, 2021at 4:30 pm as it was booked. The main aim was to know where she lived and meet other members of her family and also talk about birth preparedness and complication readiness plan. The journey was made on foot to the client's house by using the directions given. The house was a little far from the clinic. It was located near D\A School and Islamic school. She was very glad for the visit. Introduction was made that a student from Berekum Nursing And Midwifery Training Colloge sent to Adabokrom for a care studies and Madam was chosen for the studies so I decided to visit her and know where she stay.

PHYSICAL ENVIRONMENT

A quick assessment of the environment was done after which a seat and a cup of water were offered and interaction with her started. Client lived in their own house with her family. Introduction was made to the family. Client lives in their own house which is built with brinks and roof with aluminum sheet. It's a one room house with a small separated room used as kitchen. Both the inside and the outside of the house is painted blue. Their surroundings were neat and not bushy. There was a bathroom and a toilet behind the house. The floors of the room are cemented and windows made with wood.

They fetch water from a nearby bore-hole which is stored in a barrel with a plastic lid. They have electricity as a source of light. Water used for other purposes such as cooking, bathing, washing is stored in a blue coloured barrel covered with a lid. Items for delivery were brought for inspection and it was complete. She was congratulated for purchasing all the items and was encouraged to add her National Health Insurance and take money along.

As the interaction continued, the client made an attempt to crush a mosquito which was passing by. The opportunity was used to brief her on malaria in pregnancy. Enquires were made about the preventive measures. Madam Benedicta said she occasionally uses the mosquito coil .When she was asked about the use of treated mosquito nets, she said she gets suffocated each time she uses it. Comparison concerning the use of mosquito treated net and coil as to how best each could prevent mosquito bites was made. Madam Benedicta and her family were made aware that although the coil is equally good but is not as good as the treated mosquito net. This is because the coil brings a change in the circulating air and the possibility of the foetus getting suffocated would be high, since whatever air the mother inhales is shared with the foetus.

Unlike sleeping in the insecticide treated mosquito net where there is the possibility of ensuring 100 percent prevention of mosquito bite as well as ensuring free air to the foetus. Madam Benedicta was reminded on the true signs of labour, and the process of labour. She was also educated on the intake of a well-balanced diet, the importance of having enough rest, lifting of light loads and wearing of loose cloths and low heel shoes. She was again educated on her environmental hygiene. Her sister arrived just as the discussion was about to be concluded. She was encouraged to give a helping hand to reduce tiredness and promote adequate rest and sleep. She was reminded about the next visit to the clinic which was on the 8th November, 2022. Permission was sought to leave. She was very grateful. She was thanked for her cooperation and willingness to hear the advice out.

PSYCOSOCIAL HISTORY

Madam Benedicta, the husband and their daughter have a cordial relationship with each other, she has a warm and friendly relationship with the tenants, other family members staying around the house and neigbours. Her friends most of the times visit her and she also visits them at her leisure

time. She very free and likes to cracks jokes. She has respect for humans and likes to make new friends. After all interactions, Madam Benedicta and her family were then appreciated for their warm reception and permission was sought to leave.

SECOND ANTENATAL HOME VISITS

On the 13th November, 2021 Madam Benedicta was paid a visit as she was promised. A cheerful welcome was given by client. Madam Benedicta's husband and her daughter were met, they were all happy. After exchange of pleasantries, she complained of constipation, vaginal discharges and frequency of micturition but was reassured and the physiological change in pregnancy was explained to her and was told it was going to disappear after delivery.

Client was reminded of the true signs of labour and education was given to her to have enough rest and sleep, intake of fluid and nutritious foods. Madam Benedicta said her husband was being helpful in performing the household chores. Permission was sought to leave. She was thanked for her co-operation.

2.4SUBSEQUENT VISIT TO THE CLINIC

Madam Benedicta reported to the hospital on 17th November, 2021 at 8:00am as scheduled. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows;

Temperature - 36.5°C

Pulse - 81bpm

Respiration - 22cpm

Blood pressure - 100/60mmHg

Other observations were recorded as follows

Hemoglobin - 11.3 g/dl

Weight - 57.9kg

Client was asked to empty her bladder; midstream urine sample was tested for protein and glucose which were negative.

Madam Benedicta was helped onto the examination couch and privacy was ensured. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination symphysio –fundal height was 36cm and her gestational age 40weeks, lie was longitudinal, presentation was cephalic with a descent of 5/5th above the pelvic brim. On lateral palpation, the position was right occipito-anterior. On auscultation; the fetal heart rate was 139bpm. It was regular rhythmic and good volume.

All findings were communicated to her and recorded in her antenatal card. She was asked to continue her routine drugs and report to the health center if she sees any signs of labour because she was due.

2.5 NURSING CARE PLAN DURING ANTENATAL PERIOD

Nursing care plan is a written document designed to render total, individualized care to client and her family taking into consideration their needs. It involves identifying problems, analyzing them, setting objectives and implementing interventions to meet the set objectives. The care is then evaluated to know whether set goals have been achieved. In the course of this care study three nursing care plans were done for Madam Benedicta that was for antenatal, labour, and puerperium.

PROBLEMS IDENTIFIED ANTENATAL PERIOD

On 6th November, 2021, client complained of

1. Lower abdominal pain.
2. Heartburns

On 13th November, 2021, client complained of

3. Constipation
4. Vaginal discharge (leucorrhoea)
5. Frequency of micturition

SHORT TERM OBJECTIVES

1. Client‘s lower abdominal pain will be relieved and maintained throughout pregnancy.

2. Client’s heartburns will be reduced and cope with throughout pregnancy.

3. Client will have her bowel movement once within 48 hours throughout pregnancy.

4. Client’s vaginal discharge will reduce and cope with till the end of pregnancy.

5. Client will understand the reason for the frequency of micturition within 72 hours.

LONG TERM OBJECTIVE

Madam Benedicta will pass through pregnancy, labour and puerperium successfully without any complications to both mother and baby.

NURSING CARE PLAN DURING ANTENATAL CARE

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
6/11/21 at 8.00am	Lower abdominal pains related to descent of the fetal head.	Client will cope with reduced lower abdominal pain throughout pregnancy as evidence by client verbalizing that she understands the physiology and therefore managing with the pains	1. Reassure client. 2. Explain the cause of lower abdominal pains to client. 3. Encourage client to reduce household activities. 4. Encourage client to wear low heel shoes. 5. Encourage client husband to help client with household chores.	1. Client was reassured that her pain would be subsided. 2. The cause of lower abdominal pains was explained to client. 3. Client reduced household activities. 4. Client wore low heeled shoes throughout pregnancy. 5. Client's husband helped client with household chores like sweeping and washing.	08/11/21 at 8.00pm.	Goal fully met as evidenced by client verbalizing that her lower abdominal pains has reduced after intervention was given.	

NURSING CARE PLAN DURING ANTENATAL CARE

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
6/11/21 at 8:00am	Heartburns related to regulation of stomach content.	Madam Benedicta's heartburns will be reduced throughout pregnancy as evidenced by: Client verbalized heartburns has subsided.	1. Reassure client. 2. Explain the physiology of heartburns to client 3. Encourage client to elevate the head end of the bed 4. Encourage her to minimize the intake of fatty spicy meals 5.Encourage client to minimize the intake of caffeinated drinks and acidic foods. 6. Administer prescribed drugs.	1. Client was reassured that her hearburns will resolve by the end of pregnancy 2. The physiology of heartburns was explained to client. 3. The head end of her bed was elevated with pillows. 4. Client was encouraged to minimize the intake of fatty and spicy meals 5. Client was encourage to minimize the intake	8/11/21 at 8:00pm	Goal fully met as evidenced by client verbalized that waist pain has reduced and she is coping.	

				of caffeinated drinks and acidic foods. 5. Prescribed drugs was administered.			

NURSING CARE PLAN DURING ANTENATAL CARE

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
13/11/21 at 8:00am	Constipation related to activity of progesterone causing decreased peristalsis and relaxation of the smooth muscles of the large bowel during pregnancy.	Client will have her bowel movement once within 48 hours throughout pregnancy as evidenced by Client verbalizing that she was able to	1. Reassure madam Benedicta. 2. Explain the physiology of constipation to the client.	1. Client was reassured that she will have free bowel. 2. The physiology of constipation was explained to the client.	15/11/21 at 8.00am	Goal fully met as evidence by client verbalizing that she passed stool twice daily and relieved from discomfort of constipation.	

		empty her bowel freely Stating that she is relief of discomfort of -constipation.	3. Educate client to take foods rich in fiber. 4 .Educate client on the intake of fluids. 5. Educate client to engage in tolerable exercises such as - walking.	3. Client took food rich in fibre like vegetables and fruits. 4. Client took a lot of fluids. 5. Client understood the health benefits of exercises and engaged herself in tolerable - exercises.(walking)			

NURSING CARE PLAN DURING ANTENATAL CARE CONTINUES

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE / TIME	EVALUATION	SIGN
13/11/21 at 8:00am	Vaginal discharge related to increased vascularity	Client's vaginal discharge will reduce and cope with till the end of pregnancy as	1. Reassure client. 2. Explain the physiology of vaginal discharge to client.	1. Client was reassured that the discharge will reduce. 2. Physiology of vaginal discharges was explained to client. 3. Client wore cotton panties.	15/11/21 at 8:00am	Goal fully met as evidence by client verbalizing that her amount of	

	and mucus production of the genital during pregnancy.	evidenced by client: Verbalizing that her amount of vaginal discharge has reduced. 2. Midwife observing client free of vaginal - infection.	3. Encourage client to wear cotton panties. 4. Encourage client to practice good personal hygiene. 5. Encourage client to change panties frequently. 6. Encourage client to dry panties in the sun if possible or iron them.	4. Client practiced good personal hygiene like washing her panties regularly. 5. Client changed panties frequently to prevent infections. 6. Client dried panties in the sun or ironed them to reduce the rate of infections when it was possible.		vaginal discharge has reduce.	

NURSING CARE PLAN FOR ANTENATAL CARE CONTINUES

DATE / TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE /TIME	EVALUATION	SIGN
13/11/21 at 10:00am	Frequency of micturition related to the growing uterus exerting	Client will understand the reason for the frequency of micturition within 72 hours as evidence by client verbalizing:	1. Reassure client. 2. Encourage her to lean forward when voiding to help empty her bladder.	1. Client was reassured and reminded of the frequency of micturition. 2. She leaned forward when voiding.	14/11/21 at 1:00pm	Goal fully met as evidence by client verbalizing that she has been relieved of frequency of micturition.	

	pressure on the bladder.	She is able to cope with the frequency of micturition. Midwife observing that client complains less of the - frequent voiding.	3. Encourage her to urinate immediately when she has the urge. 4. Educate her on the use of panty liners. 5. Educate client on how to tighten the muscles.	3. Client urinated immediately when she has the urge. 4. Client used panty liners. 5. Client understood what was taught on how to tighten the muscles around the vagina and anus.			

CHAPTER THREE

3.0 INTRODUCTION

This chapter describes the management of first to fourth stages of labour, the immediate and subsequent care of the newborn and the care plans drawn for the management of the problems encountered during labour.

3.1 LABOUR

ADMISSION AND MANAGEMENT OF LABOUR

Admission of Client

Madam Benedicta reported to the health center with her husband on 23rd November,2021 at 2:00am which was Tuesday with complain of Lower abdominal pain and appearance of show. They were warmly welcomed and offered seats and further assured that she is in safe hands and readiness to support her. Client's antenatal card was collected and quickly glanced through with the midwife in- charge to refresh the memory on her past and present histories. Labour history was taken and was explained to her that it was engagement of the fetal head which was putting pressure on the sacral nerves. She really looked anxious, so she was therefore reassured to allay anxiety and was seen mishandling her perineal pad by touching it anyhow even when it was not soiled. Her items for delivery were nicely and neatly packed in a bag and it contained all the needed items of which it was collected and labelled. She was asked about the last meal, bowel action and any drug taken. She was made comfortable in bed and all procedures to be carried out were explained to her and her consent was sought. She was encouraged also to ask questions. Her vital signs were checked and recorded as follows;

Temperature	-	35.8°C
Pulse	-	73bpm
Respiration	-	22cpm
Blood Pressure	-	117/76mmHg

Other observation recorded as

Hemoglobin	-	11.8g/dl

A specimen bottle was given to her for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 150mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the colour of urine was amber, clear and not offensive. Hands were washed with soap under clean running water and dried with clean dry towel. Having explained the procedure and her consent sought, head to toe general examination was conducted but no abnormality was detected. The abdomen was inspected.

Inspection: Client's abdomen was ovoid in shape and medium in size. Striae gravidarum, linear nigra and fetal movement were present but no scar was found.

Palpation: The abdomen was palpated, symphysio fundal height was 36cm, and gestational age was 40weeks + 6days, the lie was longitudinal, presentation was cephalic and descent was $3/5^{th}$ palpable abdominally. Contraction was 3 in 10 minutes lasting for 40 seconds.

Auscultation: The heart rate was 142 beats per minute with good volume and regular in rhythm.

Vaginal Examination: Madam Benedicta was helped onto the lithotomy position at 2:20am. Hands were washed with soap under running water and dried with a clean towel, sterile gloves were worn for vaginal examination. The vulva was then inspected for scars, sores, warts, edema ,clitoridectomy, and abnormal discharge but none was present .

The vulva was then swabbed with sterile cotton wool swabs soaked in savlon solution. After swabbing the vulva, the vagina was entered with the middle finger and then followed by the index finger. On vaginal examination, the vagina was warm and moist, the cervix was soft ,thin and the presenting part well applied to it. The membranes intact, cervical dilatation was six (6) centimeters, presentation was cephalic, promontory of sacrum was not reached at 10 centimeters. The sacrum was well curved, ischial spines were blunt and pubic arch was wide and decent was 3/5. Hands were removed and a fist was made and it fitted into the intertuberous diameter. Madam Benedicta's perineum was cleaned and a perineal pad applied to the vulva. Client was encouraged not to sit for a very long period but encourage to walk around to help manage the pain. Madam Benedicta was encouraged to lie on her left side .She was also encouraged to pass urine frequently and when she felt the urge as that will aid in the descent of the fetal head and effective contractions and also change her perineal pad when soiled to prevent infection. Client was covered with a cloth and made comfortable in bed and was educated on the progress of labour and findings were recorded on the labour chart. She was told to assume any position comfortable to her and sacral massage was done during contractions to reduce pain. She was cautioned not to push when she felt the pains because that would make the cervix edematous and thereby prolonging labour. She was reminded of the importance of deep breathing exercise and how to do it. She was asked if she felt hungry and she replied she was okay. Client's husband and mother was offered a seat outside and he was reassured of safe delivery.

PREPARATION FOR BIRTH

Identification of helper and review of the emergency plan: The midwife in-charge who was supervising labour was chosen as a skilled helper and was informed that she may be called to help in case of emergency for the baby and mother during and after delivery. The husband of the client who was the unskilled helper was informed to be available in order to run errands when needed. Madam Benedicta had two of her relatives around who were going to donate blood in case of need .The taxi driver was also informed that his service may be needed when there is emergency. The area for delivery was prepared by drawing curtains down, testing of light and making provision for artificial lighting in case of lights out and switching off fans. Madam Benedicta's abdomen was washed and dried to prevent infection to the baby after delivery since the baby will be placed skin to skin on the mother's abdomen. She was assisted to wash and dry her hands. Preparation of an area for resuscitation and checking of equipment was also done by preparing a dry, flat and safe space for receiving the baby for resuscitation when necessary and equipments to help the baby breathe were assembled ,checked and tested for their functioning and they were in good condition. The items included the suction device, ambu bag and mask, stethoscope, scissors, timer, source of light, head covering, clothes and gloves among others. Delivery set and emergency drugs were available when checked.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph on admission when labour was established Fetal heart rate, constractions and pulse was checked every 30 minutes and vaginal examination, descent, blood pressure and temperature was done 4 hourly. She complained of fatigue and nausea. Sacral massage was done and she was reassured, the physiology behind the pains explained to her and

educated on deep breathing exercise during contractions. She was encouraged to take light nutritious diet and normal fluids in bits to prevent dehydration and to help her during the second of labour. She was also encouraged to adopt left lateral position to prevent supine hypotension syndrome. A specimen bottle was given to her for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 150mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the colour of urine was amber, clear and not offensive.

At 4:30am, client complained the edge to bear down so vaginal examination repeated, cevix was 9cm dilated with descent $1/5^{th}$,contractions 4 in 10 minutes lasting between 40 and 50 seconds with membranes still intact, foetal heart rate was 134bpm. Client's vital signs was checked and recorded as follows:

Temperature	-	36.2 degrees Celsius
Pulse	-	84 beats per minute
Respiration	-	23cycles per minute
Blood pressure	-	110/70millimeters per mercury
Fetal heart rate	-	134 beats per minute
Descent	-	$1/5^{th}$
Contraction	-	4 in 10 lasting for 40 and 50 seconds

All findings were communicated and recorded on the partograph and client was informed of progress of labour using the dilatation board, she was informed delivery was imminent and during

that period she will have the edge to bear down to defecate and therefore asked to call the midwife. The trolley was clean and a sterile delivery with other clean items were made available on both top and bottom shelf as below. Upper shelf containing the following packed in the delivery set;

- Delivery pack containing; Four clean towels
- Two artery forceps
- Two dissecting forceps
- Two gallipots (with one containing cotton swabs soaked in savlon solution and the other containing gauze)
- One cord scissors
- Receiver
- Episiotomy set
- Cord clump
- Pair of sterile gloves
- 10 units of oxytocin
- Two cot sheet
- Vitamin k injection

Lower shelf containing;

- Bed pan
- A receiver for placenta
- Container with syringes and needles
- Fethoscope
- Placenta bowl

- Extra perineal pad
- Antiseptic lotion savlon
- Rubber mackintosh
- Small cup containing water and bulb syringe
- Bed pan
- Lidocaine
- Measuring jag

Labour progressed well, client complained that she wants to defecate at 5:30am on 23th November, 2021 she ruptured membranes spontaneously, she had the edge to pass stools vaginal examination was done and the cervix was 10cm dilated, descent was 0/5th, contractions was 5 in 10 minutes lasting 46seconds and fetal heart rate was 137bpm, the perineum bulged and the anus gaped . The in-charge was informed of the progress of labour and was asked to confirm my findings and she confirmed client was fully dilated which marked the beginning of second stage of labour. Client was helped to wash her hands and chest with soap and clean water and dried with clean towel to prepare for skin to skin care. Vital signs and assessment were recorded as follows;

Temperature - 36.8 degrees Celsius

Pulse - 90 beats per minute

Respiration - 24 cycles per minute

Blood pressure - 115/60 millimeters per mercury

Fetal heart rate - 142 beats per minute

Descent - 0/5th

Contraction - 5 in 10 lasting for 40 and 50 seconds

The first stage lasted for 6 hours 30 minutes.

3.3 MANAGEMENT OF SECOND STAGE OF LABOUR

The second stage of labour starts from full dilatation of the cervix to birth of the foetus. After carrying out vaginal examination, client was informed that she was due to deliver her baby. She was asked about the position she preferred to deliver her baby with and she chose the lithotomy position and was helped to assume that position. All windows were closed and fans were turned off. Protective clothing were then worn, that is plastic apron, boots and face masks. Delivery pack was opened by the midwife in-charge and sterile gloves worn. The vulva was cleaned with cotton wool balls soaked in savlon solution. She was draped with sterile sheets on both thighs, on the abdomen and under the buttocks to maintain a sterile field for the foetus. Madam Benedicta was reminded that the baby would be delivered onto her abdomen and she agreed. With the second stage being confirmed by the last vaginal examination, she was asked to push with contractions and take rest when the contractions wear off. As she pushed and the head was advancing, a clean perineal pad was placed at the anal region to prevent the stool from contaminating the delivery field and getting in to contact with baby's face.

The middle and index fingers of the right hand were placed on the fetal advancing head to aid flexion and to allow the smallest diameter of the fetal head to distend the vulva; this was done to prevent crack or tear of the perineum. With two contractions crowning took place and the woman was asked to pant with contraction in order to prevent sudden expulsion of the fetal head. Extension of the head occurred in which sinciput, face and the chins swept the perineum and the head was

born. The eyes were cleaned immediately with sterile gauze, cleaning from the inner contour of the eyes outward using a swab at a time.

The neck was felt for cord around the neck and there was none. Restitution occurred and external rotation of the head which indicated that internal rotation of the shoulders had occurred. The fetal head was held in both palms, each palm on the parietal bones and with little downward traction, the anterior shoulder was delivered. The posterior shoulder was also delivered with upwards traction as it was allowed to sweep the perineum and with lateral flexion, the trunk and the rest of the body was delivered onto the mother's abdomen. The sex of the baby was noticed to be a female.

The baby coughed and started crying out very loudly. The baby was left on the mother's abdolmen to initiate bonding, breast feeding and to provide warmth. The baby was completely expelled at 6:00 am.

3.3 IMMEDIATE CARE OF THE BABY

This commenced as soon as the head of the baby was delivered. The eyes were cleaned with a sterile swab from within outwards, mouth and nose to enhance patent airway. The baby was placed on the mother's abdomen and dried thoroughly off the liquor and the first minute APGAR score was recorded as;

First Minute Apgar score:

TIME	COLOUR	BREATH	HEART	TONE	REFLEX	TOTAL
1 MINUTE	2	2	2	1	1	8/10

5 MINUTE	2	2	2	1	2	9/10

Within 1-3 minutes, the cord was clamped 10 centimeters away from the baby's abdomen and the cord was again clamped 8 centimeters from the mother using the forceps. The cord was covered with gauze and cut in between the clamps to separate the baby from the mother. The cord was then measured 3 finger breaths from the baby's abdomen and clamped with the cord clamp and measuring 2 finger breath above the clamp the cord was cut. The baby was made warm by wiping off the liquor and was left on the mother's abdomen for skin-to-skin to prevent heat loss and an identification band was placed at the baby's wrist with the mother's name,sex ,date and time of delivery. The condition of the baby was very good as he was actively crying and responding to stimuli.

3.5 MANAGEMENT OF THIRD STAGE OF LABOUR

This stage of labour deals with the total delivery of the placenta and membranes and control of hemorrhage. The skilled helper was asked to give 10 units of oxytocin intramuscularly at the left lateral thigh of Madam Benedicta with the aim of contracting the uterus after palpating to exclude second twin. Controlled cord traction was the method used in delivering the placenta in order to prevent retained placenta or products of conception. The cord was clamped closer to the perineum, a receiver was placed in between Madam Benedicta's thigh to receive the placenta and membranes.

The left palm was placed on the uterus to feel for contraction. With counter pressure and with the palm facing the fundus of the uterus and at the same time, the dominant hand held the clamped cord. When the uterus contracted, control traction was applied on the cord in a downward motion to deliver the placenta in the direction of the curve of carus. The steady traction was maintained

until the placenta was visible at the vulva. The placenta was cupped in both hands and was twisted to deliver the placenta and its membranes. The placenta and membranes were expelled completely at 6:10am. The placenta was placed in the receiver after quick examination was done to know whether the membranes and lobes were intact. The uterus was rubbed to stimulate contraction and expel clots. Client was taught how to perform uterine massage and also educated on how the uterus should feel after massaging. The perineum, vulva, vagina and the cervix were swabbed and examined for tears and lacerations under a good source of light but there was no tear. A clean pad was then used to clean the liquor and the blood from her body.

A clean perineal pad was also applied to the perineum and the client was asked to lie on her back and cross her legs so that any bleeding could easily be identified. She was thanked for her cooperation and efforts. She was informed to empty her bladder whenever she felt the urge in order to prevent bleeding. Her husband was informed of a safe delivey of a baby girl and he was happy.

Finally the placenta and membranes were sent to the sluice room to be examined, Placenta and membranes were immersed in 0.5% chlorine solution for ten minutes to minimize the risk of infection during examination, afterwards per the protocol of the facility placenta was discarded. Blood loss was measured or estimated as 200millimeters.

3.6 EXAMINATION OF THE PLACENTA

The placenta was placed in 0.5% chlorine solution and it was examined. The placenta was held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination.

The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fitted together without any gab and edges also forming uniform circle at the maternal surface and this indicated there was no missing lobe, there were no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe. The cord was situated at the centre of the placenta with one vein and two arteries were seen in the cord. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility.

The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of close observation of mother and baby for the first six hours after delivery to detect any deviation from normal. This stage includes prevention of disease, examination of the new born, management of the mother's condition and the baby.

3.8 PREVENTION OF DISEASE

Chloramphenicol eye drops was instilled on the baby's eyes as prophylaxis for any eye infection. The baby was covered to provide warmth to prevent heat loss, vitamin K 1.0milligram was given intramuscularly on the thigh to prevent bleeding. The baby was put to breast. She was further asked to report when she observes any bleeding, discharge and redness of the cord. Hands were washed with soap and water and dried with a clean towel.

3.9 EXAMINATION OF THE NEWBORN

The procedure was explained to client. Baby's weight was 3.1kilograms. Measurements of the baby were done and the head circumference was 34 centimeters, full length of the baby was 46 centimeters and chest circumference was 33 centimeters. Baby's vital signs were checked and recorded as follows;

Vital Sign	**Value**
Temperature	36.0 degree celsius
Apex heartbeat	160 beats per minute
Respiration	44 cycles per minute

Examination gloves were worn and baby was examined in the presence of the mother in a clean and warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of the baby was checked to be normal. The colour was pink, chest was moving normally and baby was active. A detailed head to toe examination was carried out to detect any abnormality.

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

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

Mouth: The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was also no false tooth noticed. The palate

was high arched, intact and the vulva centrally placed. There was no cleft palate or cleft lip or tongue tie.

Ears: The ears were inspected, the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for its softness. The shape and size was also noted and no abnormality was detected.

Neck: The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good.

Chest and Abdomen: The chest was examined, the respiratory movement was regular and the respiratory rate was 44cpm. The space between the nipples was checked and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord. The cord was examined and there was one vein and two arteries.

Upper Extremity: Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. The shape and colour of the fingers were inspected for reflexes (grasping, moro) and they were normal. Hands were again examined and there were no abnormalities like clubbing, extra or missing digits, nail growth and webbing.

Genitalia and Anus: The genital area was examined. By inspected the labia, clitoris, vagina, and urethra for potency, foreign bodies and discharged. The anus was inspected for position, fissures, fistulas, hemorrhoids, sphincter tone, tenderness and patency

Lower Extremity: The length and movement of the limbs were also noted. The digits were counted to be normal and separate to exclude webbing. The feet were examined for any disability

such talips equinovarus. The lower limbs were also examined for congenital dislocation for the hip but no abnormality was detected.

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

The baby was weighed and the weight was 3.1kg, head circumference was 34cm, length 46cm. Vitamin K 1milligram was given to baby intramuscularly to prevent bleeding disorders.

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

3.8 MANAGEMENT OF THE MOTHER AND BABY

Madam Benedicta and her baby were transferred into the lying-in room, made comfortable and also congratulated for her co-operation. Uterus was felt for contractions and her vital signs together with bleeding were monitored every 15 minutes for the first 2 hours, then 30 minutes for the third hour and hourly for the fourth, fifth and sixth hours post- delivery. 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. The first post-delivery vital signs were checked and recorded as follows; and the rest recorded on the partograph.

Temperature - 36.8 degree Celsius

Pulse - 86 beats per minute

Respiration - 22 cycles per minute

Blood pressure - 113/56 millimeters per mercury

She was encouraged to empty the bladder frequently to prevent postpartum complications such as postpartum haemorrhage and measuring of the fundal height. She was further informed that, emptying her bladder would provide comfort and ensure accurate measurement. Afterwards, a new perineal pad was applied to her vulva. She was advised on personal hygiene and exclusive breastfeeding. She was then helped to lie down comfortably.

3.9 CONDITION OF MOTHER

Blood pressure - 113/56 millimeters per mercury

Fundal height - 16centimeters

Uterus - Contracted

Lochia - Red (rubra)

Urine output - 100mls

Mother's condition was satisfactory.

3.10 CONDITION OF BABY

Sex - Female

Birth weight - 3.1kilograms

Length of the baby - 46centimeter

Temperature 36.7 kg

Head circumference - 34 centimeters

Apgar Score

First minute score - 8/10

Fifth minute score - 9/10

Meconium - Passed

Urine - Passed

Baby's condition was satisfactory.

DURATION OF LABOUR

Duration of first stage - 6hours 30minutes

Duration of second stage - 30minutes

Duration of third stage - 10minutes

Total duration of labour - 6 hours 10minutes

3.11 NURSING CARE PLAN ON LABOUR

PROBLEMS IDENTIFIED

0n 23rd November, 2021 Client complained of

1. Excessive sweating

2. Anxiety

3. Signs for urinary tract infection

4. Fatigue

5. Nausea

SHORT TERM OBJECTIVES

1. Client will be relieved of excessive sweating 30minutes after labour.
2. Client will be relieved of anxiety by the end of labour.
3. Client will show no sign of urinary tract infection after delivery and puerperium.
4. Madam Benedicta will have energy to bear down throughout labour.
5. Client's nausea will be relieved 30minutes after labour.

LONG TERM OBJECTIVE

Client will go through all stages of labour safely without any complications to herself and the unborn baby.

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 3:00am	Excessive sweating related to stress of labour.	Madam Benedicta will be relieved of excessive sweating 30minutes after labour as evidenced by midwife observing that client is not dehydrated and	1. Reassure Madam Benedicta. 2 .Provide fresh air to client by putting on fan. 3. Clean face and body of client with wet towel. 4. Encourage and supervise client to practice deep breathing exercise. 5. Serve cold drinks	1. Madam Benedicta was reassured. 2. Fan was put on to provide fresh air to client. 3. Client face and body were cleaned with towel. 4. Deep breathing exercise was encouraged.	23/11/21 at 8:00am	Goal fully met as evidenced by client not sweating and was comfortable.	

		with minimal sweating.					

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 3:00am	Anxiety related to unknown outcome of labour.	Client will be relieved of anxiety by the end of labour as evidenced by client delivering a healthy baby without any	1. Reassure client. 2. Establish and maintain good interpersonal relationship between you and the client. 3. Explain every procedure before and after implementation.	1. Client was reassured. 2. Good interpersonal relationship was established. 3. Every procedure was explained to client.	23/11/21 at 8:30pm	Goal fully met as client delivered a healthy baby with no complication. 2. Client observed to be relaxed in bed.	

		complication or trauma.	4. Communicate all findings to client. 5. Introduce successful women to client.	4. Findings were communicated to client. 5. Successful women were introduced to client.			

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 3:00am	Signs for urinary tract infection related to mishandling of perineal pad	Client will show no sign of urinary tract infection after delivery and puerperium as evidenced by;	1. Reassure client. 2. Encourage client to wash her hands before and after touching perineal pad. 3. Educate client on the need to change perineal pad whenever soaked to prevent infections.	1. Client was reassured that she will be free from infections. 2. She washed her hands before and after touching perineal pad. 3. Client changed perineal pad when soaked to prevent infections.	24/11/21 at 8:00am	Goal successfully met as Midwife reported that client showed no signs of infections such as rise in body temperature.	

		The midwife visualizing that she shows no symptoms of infections and recording normal body temperature.	4. Educate client not to reapply perineal pad when it falls. 5. Explain to the client the -need for proper handling of pad.	4. Client changed perineal pad when it falls. 5. Client handed perineal pad well.			

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/21 at 3:00am	Fatigue related to physiological activities that occurred in labour.	Madam Benedicta will have energy to bear down throughout labour as evidenced by Client verbalizing	1. Reassure client. 2. Encourage client to rest in between uterine contractions. 3. Encourage client to take in fluids to boost her energy.	1. Client was reassured that she will be relieved of her fatigue. 2. Client rested in between contractions. 3. Client took in fluids to boost her energy.	23/11/21 at 8:00am	Goal fully met as client was active throughout period of labour had a safe delivery.	

		that she is much stronger now. .	4. Encourage client to practiced deep breathing exercise. 5. Give client oral fluids. 6. Provide quite environment.	4. Deep breathing exercise was encouraged. 5. Oral fluid (fruit juice) was given to client to hydrate her. 6. Quite environment was provided.			

NURSING CARE PLAN ON LABOUR

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE /TIME	EVALUATION	SIGN
23/11/2 1at 3:00am	Nausea related to hormonal	Client's nausea will be relieved after labour as	1. Reassure client. 2. Encourage client to eat light foods in bits.	1. Client was reassured. 2. Client was encouraged to eat light foods in bits.	23/11/21 at	Goal fully met as evidenced by midwife observing	

	actions in labour.	evidence by client verbalizing that her nausea has stopped.	3. inform client to rinse the mouth with mouth wash 4. Educate client on the causes of nausea. 5.Remove nauseating objects	3. Client was informed to rinse the mouth with mouthwash. 4. Client was educated on the causes of nausea. 5. Nauseated objects removed.	6: 00pm	client nausea has stopped.	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

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

4.1 DAY OF DELIVERY

Madam Benedicta and baby were sent to the lying-in six hours after for close observation when her condition was satisfactory. She was made comfortable in bed with baby. Both mother and baby were kept warm. She was encouraged to put the baby to breast to promote bonding between them and also stimulate uterine contractions to aid involution of the uterus. She was also encouraged to empty the bladder frequently to help in fast involution of the uterus and also to prevent the occurrence of postpartum hemorrhage.

An opportunity was taken to educate her on exclusive breastfeeding for the first six months, emptying of one breast before the other and the need to feed the baby frequently at least 8 to 12 times a day, as well as how to fix the baby to breast. She was also educated to keep the baby warm to prevent hypothermia, and educated to change the baby's soiled napkins frequently to prevent nappy rash and to make the baby comfortable. She was encouraged to wash her hands with soap and water after visiting the lavatory, changing her perinea pad, removing the baby's soiled napkins and also before and after touching the baby. It was explained to her the need to change her perinea pad frequently. Madam Benedicta took fufu and light soup for supper. Her vital signs were checked

and recorded as follows;

Temperature	-	36.5ºC
Pulse rate	-	80bpm
Respiratory rate	-	22cpm
Blood pressure	-	109/68mmHg

The symphysio fundal height was measured to be 16centimeters. Lochia were also inspected and it was red (rubra) in colour and small in amount with no bad odour. The baby was examined from head to toe and no abnormality was detected. The client's relatives were asked to excuse mother and baby so that they could have some rest and sleep. Client complained of after pains. Physiology of after pain was explained to her, tablet paracetamol 1g was served with good effect. Warm compresses were applied to the lower abdomen. Client was educated to urinate frequently since full bladder could alter uterine contractions and bring about postpartum hemorrhage. She was also encouraged to try and walk about in order to aid in drainage of lochia. Again she was advised to change her sanitary pad frequently since she was at risk of infection. She was educated on the importance of hand washing before and after changing of her sanitary perinea pad.

Madam Benedicta was encouraged to eat good nourishing and balanced diet, adequate intake of fluids, more fruits and roughages to enhance bowel movement and to help repair all worn out tissues. She was again encouraged to rest and sleep and exercise especially the abdominal and pelvic floor exercises.

Madam Benedicta's mother and husband was advised to help his wife in the care of the baby and also the household chores. She was then informed of possible discharge the next day which was on 24/11/ 2021.

4.2 SUBSEQUENT CARE OF THE BABY

After six hours, Madam Benedicta was informed about the need for baby bath and general examination of the baby and she responded positively. Head to toe examination was done and no abnormality detected and all findings were communicated to her.

BABY'S FIRST BATH

REQUIREMENTS

1. Soap

2. Sponge

3. Cream / powder

4. Sterile cotton in a gallipot or wrapped

5. Basin

6. Towels: 1 big towel and 3 small ones

7. Cot sheets 2

8. Apron

9. Gloves

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

11. Mackintosh

12. 2 jugs containing hot and cold water each

13. Two receptacles for used water and dirty linen

14. A receiver for used swab

Procedure.

All windows and doors were closed, fans switched off and lights switched on to make the room warm. Procedure was explained to Madam Benedicta and was thanked for accepting.

Plastic apron was then worn, hands were washed with soap and under running water and dried with a clean towel. Sterile gloves were worn and the baby was positioned on a protected flat surface, he was undressed and covered with the towel leaving the face. The general condition was observed and the baby had a pink skin colour covered with vernix caseosa. Baby's eyes were cleaned with cotton wool swab soaked in clean water from the inner canthus out and then the face was cleaned with damp face towel and dried. The baby's neck was supported with my hand, the ears were plugged with my thumb and middle finger to prevent water from entering the ears. The hair was washed with soap and sponge in a circular manner, rinse, dried and covered with clean cap.

The baby was put back on the working surface and exposed arms and front of the trunk was washed to the feet paying attention to the skin folds, then turned to the back and with one arm supported the chest and the back was washed down to the feet paying attention to the skin folds. Baby's body was immersed in a bath of warm of water, with the head supported above the water and the body

rinsed thoroughly. The baby was then placed on a cleaned cot sheet and a small cleaned dried towel was used to dry the body paying attention to the skin folds. Baby oil was applied on the skin and baby was dressed leaving the umbilical cord exposed for dressing and the hair combed neatl. Gloved hands were dipped into 0.5 percent chlorine solution and were removed and discarded, hands were washed dried with clean towel.

Mother was encouraged to observe bathing and dressing of the cord. She was educated to clean the cord as well as observed at home.

Cord Dressing

The cord was dressed by wrapping the baby in a towel to keep him warm .Mother was asked to protect him on the table. The tray containing six dry cotton wool swabs in a gallipot containing antiseptic solution which was methylated spirit and a receiver for the used swabs was already set. Hands were thoroughly washed again with soap and under running water and dried in a clean towel .Sterile gloves were worn and cord was exposed. The cord was inspected for bleeding but there was none. The tip of the cord was held with one swab in the non-dominant hand. The base of the cord was cleaned with another cotton wool swab and was discarded. The whole cord was cleaned using four of the cotton wool swabs from the base upwards. One cotton wool swab was used to clean the posterior part of the cord. The tip of the cord was dried with the swab that was used to hold it. The cord was left expose to air dry.

Baby was dressed nicely, wrapped and given to mother to breastfeed. The waste materials were discarded according to infection prevention protocol. Gloves were removed and discarded. Hands were washed with soap and water before handling the baby.

Vital signs were also checked and the findings were communicated to the mother and documented as follows:

Head circumference	-	34centimeters
Length	-	46 centimeters
Weight	-	3.0kilograms
Pulse	-	142 beats per minute
Temperature	-	36.3 degree Celsius
Respiration	-	42 cycles per minute

Baby's condition was good.

At 5:00 pm mother and baby were seen to find out how they were faring, they were in good condition.

FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-delivery was 24th November, 2021. Mother and baby were seen in the lying- in ward at 8:00am to find out how they were faring. Greetings were exchanged and Madam Benedicta was asked about how she and the baby were doing and she said they were both doing well, except that she had after pains while breast feeding the baby. She was reassured and educated on the physiology of after pain that is a normal physiology thus the suckling triggers the release of oxytocin which causes uterine contraction and therefore causes lower abdominal pain. She was given paracetamol 1g to reduce the pain. Madam Benedicta also complained of less sleep because the baby cried a lot during the night. She was encouraged to attend to the baby whenever it cried

in the night and have enough sleep when the baby is asleep. She was urged to change baby diapers when wet. She had already emptied her bladder and taken her bath. So permission was sought for head to toe examination. A puerperal assessment was then made. The conjunctiva was inspected for sign of anemia but it was absent. The breasts were lactating very well and the uterus was well contracted when palpated and measured, the symphysio fundal height measured 15cm. The perinea pad was inspected and the Lochia was red (rubra), with moderate flow and there was no offensive odour. She was then encouraged to ambulate to promote effective circulation and drainage of lochia. She took her baby after she was served with hausa porridge and a loaf of bread as breakfast. Madam Benedicta's vital signs were checked and recorded as follows;

Temperature - 36.5 degree Celsius

Pulse - 82 beats per minute

Respiration - 22 cycles per minute

Blood pressure - 110/60 millimeters of mercury.

Mother was educated not to apply hot compress on baby's head with the intention of closing the fontanels that was explained to her that the fontanels close naturally. And also how to position herself when breastfeeding, how to put the baby to breast were demonstrated to her to enable her breastfeed well and prevent breast sore.

Baby was also examined with permission from the mother after hand washing was done with soap and under running water and dried with clean towel. A thorough head to toe examination was performed on the baby again but no abnormality was detected. The cord was inspected for bleeding, odour and discharge but there was none. The baby was top and tailed with the cord

dressed with methylated spirit. The baby was dressed nicely and wrapped in a clean warm sheet. Baby's vital signs checked and recorded as follows;

Temperature - 36.5 degree Celsius.

Pulse - 132 beats per minute.

Respiration - 40 cycles per minute.

Weight - 3.0 kilograms.

The baby was given the first immunization Bacilli Culmette Guerine (BCG)0.05millimeters vaccine intra dermal on the right upper arm for protection against tuberculosis. Client was educated that she should not apply anything on the injection site or massage it. She was told that there could be a tissue reaction over the area, a scar formation later indicating that the child had been immunized against tuberculosis effectively. Polio vaccine of 2 drops at de back of the tongue was also given orally to protect the baby against polio myelitis. Vitamin K giving to prevent bleeding. Chloramphenicol eye drop given to prevent infections. Client was educated to continue with baby's immunization schedule at well baby clinic. This would help prevent baby contracting any of the childhood preventable diseases. Client was also told to register the baby at the birth and death unit and complete all the immunization schedules.

Mother was educated on personal hygiene, post natal exercise, keeping the baby's cord clean, dry and avoid the application of unprescribed medication on it, change baby's diapers or napkins frequently when soiled and wash and dry in the sun, take in nutritious diet and fruits which are available, provision of warmth to the baby and prevention of infection by changing her perinea pad whenever it was soiled and also she was educated on exclusive breastfeeding and the need to feed on demand and at night which will serve as family planning as well as aiding in involution.

Client was informed about her discharge. She was encouraged to sleep under treated mosquito net together with the baby to prevent malaria. I was assisted by her mother, to pack her belongings, and her health insurance card was used to settle her bills. Prescribed drugs were given as below;

Iron III polymaltose complex capsule (daily) for30 days

Amoxycillin capsule 500mg (three times daily) for 7days

Metronidazole tablet 400mg (three times daily) for 7days

Paracetamol tablet 1g (three times daily) for 5days

The dosage and time for taking the drugs were explained to her. Madam Benedicta was also told that she would be visited for one week to check on her condition and that of the baby and continued with their care. She was discharged home at 12:00pm and was escorted with her items into a car brought by her husband. 30th November,2021 was scheduled as date for one week visits. They were reminded of the visit to their house and bid them farewell as the car drove off.

4.4 FIRST DAY POST NATAL HOME VISIT

Madam Benedicta was visited in her home in the evening at 5:00pm as scheduled that is on the 24th November, 2021. On arrival, greetings were exchanged with a warm welcome. She was neatly dressed and had already set the place for the baby to be bath; the baby was then toped and tailed. It was explained to her that physical examination will be done on her and the baby, dress the baby's cord and also check her vitals. The cord was dressed with cotton wool swabs soaked in methylated spirit. Mother was also examined from head to toe and there were no abnormal changes. The fundal height measured 15cm. The perineum was inspected and was found to be cleaned, lochia was red (rubra) with moderate amount of flow. Her vital signs were taken and recorded as;

Temperature : 36.4 degree Celsius

Pulse : 78beat per minutes

Respiration : 21cycle per minutes

Blood pressure : 110/72millimeters of mercury

Baby was not jaundiced or pale and was able to suckle well. The baby's vital signs were taken and recorded as follows;

Temperature : 36.8degree Celsius,

Pulse : 134 beats per minute,

Respiration : 46 cycles per minute.

Baby's weight : 3.0 kilograms

Cord Clean

Suckling Yes

Stool colour Greenish

Madam Benedicta was encouraged to breastfeed the baby on demand. A promise was made to visit them again the following day and client said good bye and the family were bade farewell.

4.5 SECOND DAY POST-DELIVERY.

On 25th November, 2021, the second visit was made to Madam Benedicta's house at 7:30am in the morning as scheduled. Madam Benedicta said her condition had improved. Baby was also doing well. The family was pleased. Permission was sought from Madam Benedicta to inspect her perinea pad and perinea area was clean and the lochia was red (rubra), not offensive and the flow

was moderate. She was asked to empty her bladder before the examination. She emptied her bladder and the Head to toe examination was carried out and everything was normal. The breasts were firm and well lactating. Uterus was firm and symphysio fundal height measured 14cm.General examination was carried out on the baby from head to toe and no abnormality was revealed. Baby was toped and tailed. The cord was neatly dressed and it was dry with no sign of infection. The baby passed stools and urine. Mother and baby's vital signs were taken and recorded as follows;

Observation on Mother

Observation	**Morning**
Temperature	36. 2degree Celsius
Pulse	78 bpm
Respiration	20 cpm
Blood pressure	110/60 mmHg
Lochia	Rubra
Fundal height	14cm
Condition of the uterus	Contracted
Breast	Lactating

Observation on Baby

Observation	**Morning**

Temperature	36.7
Pulse	134 bpm
Respiration	42 cpm
Cord	No bleeding
Skin Colour	Pink
Suckling	Yes
Weight	2.9kg
Stool Colour	Greenish

Baby was wrapped in warm sheet. He was handed over to the mother to breastfeed. Madam Benedicta was thanked for her cooperation and permission was sought to leave, which was granted.

Evening

Family members were in good health on arrival at 4:30pm, greetings were exchanged and a seat was offered. She was asked about her health and that of the baby of which she responded they were fine. The family was very cooperative which created a relaxed and lovely environment. Examination was done on the mother and no abnormality was detected. Mother's vital signs checked recorded as follows;

Observation on Mother

Observation	**Evening**
Temperature	36.4 degree Celsius
Pulse	74 bpm

Respiration	23 cpm
Lochia	Rubra
Fundal height	14 cm
Condition of the uterus	Contracted
Breast	Lactating
Blood Pressure	111/73 mmHg

Baby was top and tailed while I asked both mother and father including the family members to observe the procedure. After which baby's cord was dressed with spirit. Cord was clean and dried with no offensive odour. Head to toe examination was done on the baby and nothing abnormal was seen. Baby's vital signs were checked and recorded as ;

Observation on Baby

Observation	**Evening**
Temperature	36.7
Pulse	130 bpm
Respiration	40 cpm
Skin Colour	Pink
Cord	Clean
Suckling	Yes
Weight	3.2kg
Stool colour	Greenish

Baby was wrapped in warm sheet and handed over to the mother to be breastfeed. Madam

Benedicta was thanked for her cooperation and permission was sought to leave, of which she granted and said she was very grateful and appreciated for the care that was given to them.

4.6 THIRD DAY POST-DELIVERY.

On the 26th November, 2021, the third home visit was made to Madam Benedicta's house at 7:30am in the morning. Mother and baby were doing well. Permission was sought to inspect Benedicta's perineal pad and the lochia was red (rubra) without offensive odour. Head to toe examination was also done and everything was normal. Breasts were heavy and breast milk was flowing freely. Symphysio fundal height was measured 10cm. The baby was top and tailed, assessed and general condition was good and no abnormality was present. The cord was neatly dressed and was dry without bad odour. The baby also passed greenish yellow stools and urine.

Mother and baby's vital signs were checked and recorded as follows;

Observation on Mother

Observation	Morning
Temperature	36.6 degree Celsius
Pulse	80 bpm
Respiration	20 cpm
Blood Pressure	100/70 mmHg
Lochia	Rubra
Fundal height	13 cm
Condition of the uterus	Contracted

Breast	Lactating

Observation on Baby

Observation	**Morning**
Temperature	36.6 degree Celsius
Pulse	140 bpm
Respiration	42 cpm
Skin colour	Pink
Cord	Clean
Suckling	Yes
Weight	2.8kg
Stool colour	Greenish

Evening

At 5:00pm in the evening, both mother and baby were visited. Nothing abnormal was detected during the examination. Madam Benedicta complained of interrupted sleeping pattern because baby normally cries at night. She was reassured and encouraged to breastfeed baby well before bed time and to change the baby's napkin when soiled. She was reminded on exclusive breastfeeding and on demand, maintenance of personal hygiene, eating of fruits and highly nutritious diet and warm saline sit-bath on each visit. Family members were encouraged to care for the baby at night so that mother could have adequate sleep.

Mother and baby's vital signs and other observations were taken and recorded as follows;

Observation on Mother

Observation	Evening
Temperature	36.4 degree Celsius
Pulse	82 bpm
Respiration	24 cpm
Blood pressure	100/60
Lochia	Rubra
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactating

Observation on Baby

Observation	Evening
Temperature	36.4
Pulse	140 bpm
Respiration	45 cpm
Skin colour	Pink
Cord	Clean
Suckling	Yes
Weight	2.8kg
Stool colour	Greenish

Again, permission was sought to leave from Madam Benedicta of which granted. She was thanked

and a bid was made.

4.7 FOURTH DAY POST-DELIVERY

Madam Benedicta and her baby were visited again on 27th November, 2021 in the morning at 8:00 am to continue with the postnatal care. She and her baby were physically examined and nothing abnormal was detected. Lochia was Serosa on inspection, no odour and breasts were lactating. Head to toe examination was done and everything was normal. Symphysio fundal height measured 12cm. Baby had been bathed by client's mother on arrival so the general examination was carried out. No abnormality was found. The cord was neatly dressed and has shrinked with no abnormality detected. Madam Benedicta complained of fullness in the breast. She was educated to continue breastfeeding the baby, and to apply cold compress on them to reduce the pain. She was educated to ensure that one breast was empty before the other one was given to the baby. Mother and baby's vital signs were checked and recorded as follows;

Observation on Mother

Observation	Morning
Temperature	36.7
Pulse	80 bpm
Respiration	23 cpm
Blood Pressure	110/60mmHg
Lochia	Serosa
Fundal height	12 cm
Condition of the uterus	Contracted
Breast	Lactating

Observation on Baby

Observation	Morning
Temperature	36.8Oc
Pulse	133bpm
Respiration	44cpm
Weight	2.8 kg
Cord	Dry
Suckling	Yes
Stool colour	Yellowish

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

4.8 FIFTH DAY POST- DELIVERY.

The 5th postnatal home visit was on 28th November, 2021 at 8:30am to continue with the post-natal care. Mother and baby were both in a healthy condition. Inspection of the lochia was done and the colour was serosa with symphysio fundal height measured 8cm. After the head to toe examination, no abnormality was detected. Client's vital signs were checked and recorded as follows:

Observation on Mother

Observation	Morning
Temperature	36.5

Pulse	87 bpm
Respiration	22 cpm
Blood pressure	100/70mmHg
Lochia	Serosa
Fundal height	11cm
Condition of the uterus	contracted
Breast	Lactating

Head to toe examination was done and no abnormality was found on the baby. The cord was dry and not completely off so baby was topped and tailed. The baby urinated and passed yellowish stool and was cleaned immediately. Vital signs and other observations were taken and recorded as follows:

Observation on Baby

Observation	**Morning**
Temperature	36.4
Pulse	129bpm
Respiration	45 cpm
Weight	2.9kg
Cord	Dry
Suckling	Yes
Stool colour	Yellowish

Madam Benedicta was reminded of the next visit and she said she was very grateful, permission was sought and she was thanked for her cooperation.

4.9 SIXTH DAY POST-DELIVERY.

The 6th day postnatal home visit was made on 29th November, 2021 at 7:00am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition and client said fullness of breast has subsided except that there are rashes on baby's skin and he cries a lot . She was reassured and encouraged to feed the baby well and change napkins before she sleeps and also educated to dress baby according to weather and use talcum powder on the baby's skin. Symphysio fundal height measured 10cm. Inspection of the lochia was done and the colour was serosa with odour indicating infection due to poor personal hygiene. She was educated to keep her perineum clean and change pad frequently to prevent infection and educated on family planning. After head to toe examination, no abnormality was detected.

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

Observation on Mother

Observation	Morning
Temperation	36.8
Respiration	24 cpm
Pulse	90 bpm
Blood pressure	110/70 mmHg
Breast	Lactating

Lochia	Serosa

Baby was bathed, head to toe examination was done and no abnormality was found on the baby. During the examination, it was realized that the cord had fallen off. The stump was then dressed with cotton wool swab and the area was cleaned and kept dry. Stool was yellowish in colour. Baby looked healthy and active. Baby's vital signs and other observations were taken and recorded as follows:

Observation on Baby

Observation	**Morning**
Temperature	36.7
Pulse	145 bpm
Respiration	45 cpm
Weight	3.0 kg
Cord	Off Clean
Suckling	Yes
Stool colour	Yellowish

Madam Benedicta was encouraged to continue exclusive breastfeeding. She was thanked for her cooperation and time. And also remembered her of the one-week visit, interacted for a while and permission was sought to leave.

4.10 SEVENTH DAY POST DELIVERY.

The 7th day postnatal was made on 30th November, 2021, Madam Benedicta and baby was visited as usual in the morning at 7:30am. Mother and baby were in a healthy condition and client said the baby's crying had minimized. She complained of backache. She was reassured and encouraged to adopt a good posture when breastfeeding the baby. Inspection of lochia was done and the colour was serosa (pink),flow was scanty without any bad odour. Symphysio fundal height measured 9cm. After the head to toe examination, no abnormality was detected. Mother and baby's vital signs were as follows;

Observation on Mother

Observation	Morning
Temperature	36.4
Respiration	23 cpm
Pulse	78 bpm
Blood pressure	110/60 mmHg

Baby

Observation	Morning
Temperature	37.0
Pulse	130 bpm
Respiration	42 cpm
Weight	3.1 kg
Cord	Off Clean
Suckling	Yes
Stool colour	Yellowish

She was encouraged to continue adhering to all the advices and encouragement given to her especially on nutrition, exercise, rest and sleep and maintaining good personal and environmental health.

Madam Benedicta was also encouraged to take good care of the baby and breastfeed exclusively. Client was also reminded to register the baby at the birth and death unit and complete all the immunization schedules. They were told that day was the last visit.

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Benedicta and her baby reported at the hospital on 30th November, 2021 at 9:00am accompanied by her mother. Mother and baby looked healthy and cheerful. They were welcomed to the postnatal site and a seat was offered to them to listen to a health talk on immunization against

the preventable childhood disease, exclusive breastfeeding and family planning.

After the talk client and baby were taken to the examination room to be examined. With permission from mother, baby was undressed and wrapped in a clean cot sheet and was put on a flat surface in the presence of the mother. Procedure was explained to Madam Benedicta and hands were washed and dried. The fontanels and sutures were examined for any bulging fontanels or widening sutures but there were none. The eyes, nose and ears were examined and no abnormalities were detected. Baby had no rushes or bruises on the skin. The abdomen was soft, not distended, and the umbilical cord was completely healed. The extremities and the back were also examined and there were no abnormalities.

Baby's weight was 3.1kg and his vital signs checked and recorded were as follows:

Temperature	-	36.7°C
Pulse	-	134bpm
Respiratory rate	-	42cpm

All findings were communicated to mother and recorded. Mother claimed the baby has good bowel movement and breastfeed well.

Madam Benedicta was also examined and was asked to empty her bladder for physical examination after the procedure has been explained to her. She was assisted onto the examination couch and privacy was provided. Fundus was not palpable. Hands were washed and dried. Her vital signs checked and recorded as;

Temperature	-	36.5°C

Pulse rate - 84bpm

Respiration - 24cpm

Blood pressure - 103/74 mmHg

On inspection, client's hair was clean and nicely plaited her conjunctive and sclera was pink without any pallor. The nose, mouth and ears were clean without any discharges. The breast was heavy, soft and lactating well with healthy nipples. The upper and lower extremities were without oedema and her back was normal. The lochia was scanty and creamy white. She was helped out of the examination couch after the examination. Findings were communicated to her and documented.

Madam Benedicta was advised to maintain good personal and environmental hygiene in the care of herself and the baby. Madam Benedicta was again educated on her nutrition and was asked to eat foods that are rich in proteins and vitamins, she was encouraged to continue with exercise and have adequate rest and sleep. Client said the backache has subsided. Madam Benedicta was encouraged to register her baby at the birth and death registry since there was none at the health center. Client was reminded of the six weeks postnatal visit to the clinic. Gratitude and thanks were expressed to Madam Benedicta and the entire family for their support and co-operation throughout the writing of the care study. She was finally handed over to the public health nurse in-charge to continue with the care.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in- charge, Madam Benedicta's six weeks postnatal visit was on 4th January, 2022. At 9:00am She came to the facility with her husband. Head to toe examination was

done on Madam Benedicta and nothing abnormal was present. Her vital signs, including the weight were checked and recorded as follows;

Temperature	-	36.5oc
Pulse	-	80 bpm
Respiration	-	20cpm
Blood pressure	-	110/60 mmHg
Weight	-	63kg

Madam Benedicta's urine was checked for protein and sugar and it was negative for both, and the haemoglobin was 12.0g/dl. Her fundus was not palpable and no lochia observed.

The baby was examined from head to toe and no abnormality was found. The following immunizations were given to the baby;

Vaccine	Dosage	Route of Administration
Polio 1	2 drops	Oral
Rotarix	2 drops	Oral
Penta	0.5 millimeters	intramuscularly on right thigh

Baby's vital signs and other observations were checked and recorded as:

Temperature	-	36.2degree Celsius
Respiration	-	24 cpm

Pulse - 142bpm

Weight - 5.0 kg

Mother was encouraged to practice exclusive breastfeeding for 6 months to inhibit ovulation and prevent infection or any disease to the baby. Client was congratulated for taking good care of the baby as seen in the baby's weight gain. She also expressed her gratitude for all the support offered to them. She was also taken to the family planning unit and the child welfare clinic for immunization and continuity of care.

4.13NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. After pain. (24th November 2021).
2. Sleeplessness. (26th November,2021).
3. Breasts engorgement. (27thNovember 2021)
4. Rash on baby's skin. (29th November 2021)
5. Backache. (30th November 2021)

SHORT TERM OBJECTIVES

1. Madam Benedicta after pain will be relieved within 48 hours.
2. Client will have at least 6hours sleep within 72 hours.
3. Client's breast engorgement will be relieved within 72 hours.
4. Baby will have no skin rashes on skin within 72 hours.
5. Client's backache will be relieved within 72 hours.

LONG TERM OBJECTIVE

Mother and baby will pass through puerperium without any complications.

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
24/11/21 at 7.00am	After pain related to involution of the uterus.	Madam Benedicta's after pain will be relieved within 48hours as evidenced by client verbalizing her after pain has reduced. 2. Midwife visualizing that client is relived of- after pain.	1. Reassure client. 2. Explain the cause of pain to client. 3. Encourage client to assume any comfortable position of her choice. 4. Encourage client to empty her bladder frequently. 5. Serve her with prescribed analgesics.	1. Client was reassured. 2. The cause of pain was explain to her. 3. Client assumed any comfortable position of her choice. 4. Client emptied her bladder frequently. 5. Client was served with analgesics (Paracetamol 1g).	26/11/21 at 7:00am	Goal fully met as 1. Madam Benedicta verbalized that her after pain has reduced. 2. Midwife visualized that client look cheerful on assessment.	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
26/11/21 at 5:00pm	Sleeplessness related to baby's crying and feeding at night.	Client will have at least 6hours sleep within 72 hours as evidence by client verbalizing that she now sleeps for at least 6 hours at night and 2 hours during the day.	1. Reassure the client. 2. Encourage client to practice kangaroo mother care. 3. Encourage client to sleep when baby is asleep. 4. Encourage her support person to help her in the household chores.	1. Client was reassured. 2. Client practiced kangaroo mother care. 3. Client slept when baby was asleep. 4. Her relatives helped her in the household chores like washing to enable her to sleep during the day.	28/11/21 at 5:00pm	Goal achieved as client verbalized that she's able to sleep well at night.	

			5. Encourage client to rest- during the day.	5. Client rested during the day.			

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
27/11/21 at 4:30pm	Breast engorgement related to inadequate emptying of the breast.	Client's breast engorgement will be relieved within 72 hours. as evidenced by Client verbalizing that she feels comfortable in her breast and the midwife visualizing that	1. Reassure client. 2. Teach client on how to fix baby correctly to the breast. 3. Teach client how to correctly position herself when breastfeeding. 4. Encourage client to empty breast when not feeding.	1. Client was reassured. 2. Client was taught how to fix baby correctly to the breast. 3. Demonstration was done to client on how to position baby during breastfeeding. 4. Client was encouraged to empty the breast.	29/11/21 at 4:30pm	Goal fully met as client reported that she has been relieved of breast engorgement.	

		the fullness is reduced.	5. Encourage client to continue breastfeeding the baby exclusively. 6. Encourage client to apply cold compress to the breast.	5. Client was encouraged to continue breastfeeding the baby exclusively. 6. Client was encouraged to apply cold compress to the left -breast.			

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
29/11/21 at 7:00am	Skin rashes on baby related to excessive dressing of baby.	Baby will have no skin rashes on skin within 72 hours as evidenced by client verbalizing that the	1. Reassure client. 2. Educate client on the need to clothe baby according to the weather. 3. Educate client not to scratch the rashes.	1. Madam Benedicta was reassured. 2. Client dressed baby in warm cotton cloths and according to the weather changes.	1/12/21 at 7:00am	Goal met as Madam Benedicta informed the midwife that	

		baby skin rashes has resolved. 2. Midwife observing that baby-is having no rashes.	4. Teach client how to use prescribed powder.	3. Mother did not scratch the rashes as it would cause more pain and infection. 4. Client was taught on how to use the prescribed powder for the rashes example vasline, shea -butter and Listerine powder.		baby's skin rashes has resolved. 2. Midwife observed that baby has no skin rashes.	

NURSING CARE PLAN ON PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUT COME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN.
30/11/21 at 4:30pm	Backache related to weight of pregnancy.	Client's backache will relieved within 72 hours as evidenced by	1. Reassure client. 2 Teach client how to position herself when breastfeeding. 3. Teach client other breastfeeding methods.	1. Client was reassured. 2. Client was taught how to position herself when breastfeeding. 3. Client was taught other breastfeeding methods.	2/12/21 at 4:30pm	Goal met as evidenced by client verbalizing that she is relieved of pain.	

		1. Client verbalizing that pain has relieved. 2. Midwife observing -client assume good posture during breastfeeding.	4. Encourage client to support her back with pillow when sitting to breastfeed baby. 5. Educate client against lifting heavy loads. 6 Encourage family members to -support in the care of the newborn.	4. Client supported her back with pillow when sitting to breastfeed baby. 5. Client was educated on lifting heavy loads. 6. The family members were -encouraged to help in the care of the baby.		2. Midwife observing that client look cheerful on assessment and assumed good -posture change when breastfeeding.	

5.0 TERMINATION OF CARE

Explanation was given to Madam Benedicta 0n the need to be handed over to the midwife in charge for continuity of care on the 30th November, 2021 at 9 :00am. Explanation was made to her that our programme will end on the 17th December, 2021 but client was reassured of midwife in-charge's competency. Client was accompanied to her house and a seat was offered. Client and her sister together with her husband were thanked for their cooperation, information provided throughout the study, they were reminded to register the baby at the birth and death registry. And also to complete baby's immunization schedule and permission was sought to leave.

SUMMARY AND CONCLUSION

This script is a Family Centered Maternity Care, given to Madam Benedicta a 21 years old woman gravida 2 Para 1. She hails from Berekum Ayimo in the Bono Region. She was met at Adabokrom Health Centre, on 1st November, 2021 when she was 37 + 5weeks pregnant. Various observations, examinations and Laboratory investigations were carried out to aid in her care. Client went through pregnancy with some minor disorders which were managed successfully.

Madam Benedicta's labour and delivery were managed carefully without any complications. She delivered spontaneously an alive female infant with birth weight 3.1 kg on the 23th November, 2021 at 6:00am who cried immediately after birth.

Madam Benedicta's puerperium was successful, mother and baby were visited at home and finally handed over to the Community Health Nurse for further management on 30th November, 2021.

The Family Centered Maternity Care has afforded me the opportunity to identify the various needs of the expectant woman during pregnancy, labour and puerperium .

The knowledge and experience acquired will be translated to other expectant mothers, their families and the community members during my practice as a midwife.

In conclusion, the client/family centered maternity care study has exposed the writer to situation where the knowledge received in the classroom has practically been demonstrated on the client and family from pregnancy to puerperium. This has also enhanced my ability to perform them and render them to any pregnant woman in the course of practice wherever to help reduce maternal and infant morbidity.

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APPENDIX 1 MOTHER'S ANTENATAL RECORDS

MOTHER'S ANTENATAL

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRES ENT A- TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH R)	TREATMENT GIVEN	COMPLAINS	SIGN
10/6/21	52.4kg	100⁄70mmHg	negative ⁄ negative	17+5weeks	15	-	-	-	Routine drugs	Doing well	MC
8/7/21	52.9kg	90/60mmHg	negative⁄ negative	21+2weeks	18	-	-	-	Routine drugs	Doing well	MC
16⁄8⁄21	55.2kg	100/60mmHg	negative⁄ negative	26+5weeks	26	Ceph	5/5	132	Routine drugs.	Doing well	AP
20/9/21	56.9kg	90/60mmHg	negative⁄ negative	31+5weeks	2 8cm	Ceph	5/5	140	Routine drugs.	Feels well	AF

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
7/10/21	56.7kg	100/60mmHg	negative/ negative	34+1weeks	30cm	Cephalic	5/5	144	Routine drugs.	Vomiting	MC
18/10/21	58.1kg	90/60mmHg	negative/ negative	35+5weeks	32cm	Cephalic	$5/5^{th}$	138	Routine Drugs	Skin rashes	MC
25/10/21	57.6kg	90/60mmHg	negative/ negative	36+5weeks	33cm	Cephalic	$5/5^{th}$	133bpm	Routine Drugs	Doing well	AP
1/11/21	57.7kg	100/60mmHg	negative/ negative	37+5weeks	34cm	Cephalic	$5/5^{th}$	142bpm	Routine drugs	Feeling well	PA
11/11/21	58.1kg	90/60mmHg	negative/ negative	39+1weeks	37cm	Cephalic	$5/5^{th}$	139pm	Routine drugs	Doing well	PA

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONA-L AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREAT-MENT GIVEN	COMPLAI-N	SIGN
17/11/21	57. 1kg	100/60mmhg	negative/negative	40weeks	36cm	Cephalic	5/5th	139bpm	Routine drugs	Doing well	PA

APPENDIX II

COMPLETE DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	IVESTIGATION	NORMAL VALUES
10/6/21	1. Blood	Haemoglobin level Sickling status Grouping and Rhesus factor HIV status VDRL Hepatitis status G6PD status	12g/dl-16g/dl Negative A, B, AB, and O Positive and negative None reactive None reactive Negative None reactive
	2. Urine	Sugar Protein	Negative Negative
8/7/21	1. Urine	Sugar Protein	Negative Negative
16/8/21	1.Urine	Sugar Protein	Negative Negative
20/9/21	1.Urine	Sugar Protein	Negative Negative
7/10/21	1.Urine	Sugar Protein	Negative Negative

	Blood	Haemoglobin level	12g/dl-16g/dl
18/10/21	1.Urine	Sugar Protein	Negative Negative
25/10/21	1.Urine	Sugar Protein	Negative Negative
1/11/21	1.Urine 2. Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl
11/11/21	1.Urine 2. Blood	Sugar Protein Haemoglobin level	Negative Negative 12g/dl-16g/dl
17/11/21	1. Urine	Sugar Protein	Negative Negative

Appendix III

PHARMACOLOGY OF DRUGS (MOTHER)

Drugs	**Classification**	**Dosage**	**Route**	**Actions and Uses**	**Actual Effect**	**Side Effect**	**Side Effects Experienced**
Ferrous Tablet	Haematinics	200mg daily	Orally	Aids in Red Blood Cell formation	Increase in haemoglobin level	Black stool, diarrhoea and constipation	None observed
Folic Acid Tablet	Vitamin preparation	5mg daily	Orally	Helps in the formation of blood cell	Increase in haemoglobin level	Nausea, vomiting, diarrhoea and constipation	None observed
Multivitamin Tablet	Vitamin preparation	200mg daily	Orally	Increases appetite and helps in the formation of Red	Increase in appetite	Gastrointestinal disturbance	None observed

				Blood – Cells			
Paracetamol Tablet	Antipyretics/ Analgesic	1g tds x 3	Orally	Reduces mild to moderate pain	Client pain was relieved	Liver damage due to prolong use	None observed
Tetanus Injection	Anti-tetanus drugs	0.5mg	Intra-muscular	Protect mother and foetus against infections	Client was protected against tetanus infection	Mild fever, Malaria	None observed
Metronidazole tablet	Anti-infective	400mg tds x 30	Orally	Metronidazole works by entering bacterial and protozoal cells and	Client was prevented from Infection.	Dizziness, headache, nausea,	None Observed

				interfering with their DNA.			
Sulfadoxinepyramethamine Tablet	Anti-malaria prophylaxis	3 doses stat from 16 weeks after quickening till delivery and it was given at 1month after last dose.	Orally	Prevention -of malaria	Malaria was-prevented	Urticaria rash, dizziness, nausea, stomatitis	None observed

Oxytocin injection	Oxytocin drug	10 units	Intra-muscular	Increase uterine contraction and control bleeding	Client had good uterine contraction	Vomiting, uterine spasm and raised blood pressure	None observed
Amoxicillin capsule	Antibiotics	500mg for 7 days thrice daily	Orally	Treat all kinds of infections	Prevent infections.	Nausea, vomiting, diarrhea, rash, vaginal yeast infection	None observed

PHARMACOLOGY OF DRUGS (BABY)

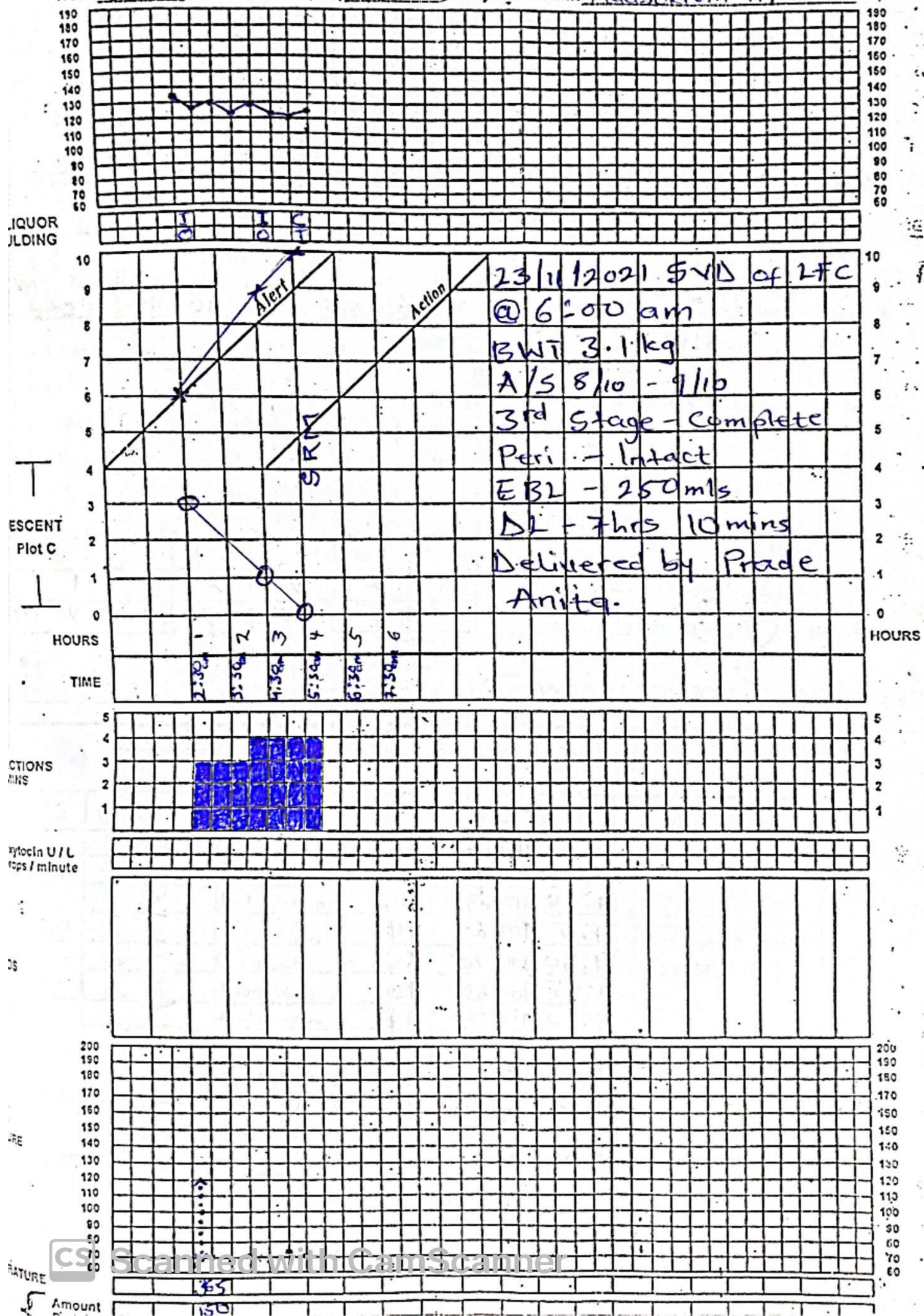
Drugs	Classification	Dosage	Route	Actions and Uses	Actual Effect	Side Effect	Side Effects Experienced
Vitamin K	Group K vitamin	1.0mg	Intra-muscular	Prevent haemolyt	No bleeding	Risk of haemolysis in	None observed

				ic diseases		people with G6PD, rashes and brain damage	
Chloramphenicol	Antibiotics	2 drops	Instillation	Prevent eye infection	Increase risk of a plastic anaemia	Ototoxicity and nephrotoxicity	None observed
Bacillus calmett Guerin injection	Antigen	0.5mg	Intra-dermal	Immunity against tuberculosis	Under observation	Mild fever, swelling of injection site and blister formation	Blister noticed
Polio O	Antigen	2 drops	Orally	Production of antibodies to prevent	Under observation	There may be diarrhoea	None observed

				poliomyelitis			
Hepatitis B vaccines	Antigen	0.5ml	Subcutaneous	Immunity against hepatitis B virus	Under observation	Fever	None observed
Diphtheria portussis tetanus	Antigen	0.5ml	Subcutaneous	Immunity against Diphtheria pertussis tetanus	Under observation	Fever	None observed
Haemophilus influenza Hepatitis B	Antigen	0.5ml	Subcutaneous	Immunity against Haemophilus influenza Hepatitis B	Under observation	Fever	None observed

WHO Modified Partograph

Registration No.: 4893/18 Name(Last, First) Kyeraa Benedicta Age: 21
Date: 23/11/2021 Parity/Gravida 1/2 LMP 10/2/21 EDD 17/11/21 Gestation(wks) 40+6
ROM: 5:40am Labour Duration (Hrs) 6hrs 10mins Facility/Clinic Name Adabokrom H/C



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LABOR NOTES

Madam Benedicta came to the facility on the 23/11/21 at 2:00 am with the complains of lower abdominal pains. Client was admitted to the ward and examination was done and vaginal examinati was 6cm dilated. so client was put on partograph. At 5:5 she complains of urge to bear ~~done~~ down and 6:00 am she delivered ~~lyfe~~ live female baby.

Please circle or write responses.

DELIVERY

DATE: 23/11/2021 TIME: 6:00 am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 6:03 am Type/Dose 10 units of oxytocin

PLACENTA: TIME: 6:10 am (Complete) / Incomplete

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

BABY

Weight: 3.1 kg
Sex: Male / (Female)
Baby Position: (Vertex) / Breech / Other

APGAR

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

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

FOURTH STAGE MONITORING

Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
Every 15 minutes first 2 hours	6:30	113/56	86	16	150	
	6:45	109/65	70	Contracted	[illegible]	100 mls
	7:00	112/63	68	contracted	[illegible]	
	7:15	109/60	74	contracted	[illegible]	Emptied
	7:30	100/70	68	contracted	[illegible]	
	7:45	104/63	70	contracted	[illegible]	50 mls
	8:00	117/73	74	Contracted	[illegible]	
	8:15	118/70	78	Contracted	[illegible]	Emptied
Every 30 minutes For 1 hour	8:45	110/63	76	Contracted	[illegible]	
	9:15	113/65	72	contracted	[illegible]	Emptied

Birth Attendant PRADE. AMITA Date 23RD NOV, 202

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Scanned with CamScanner

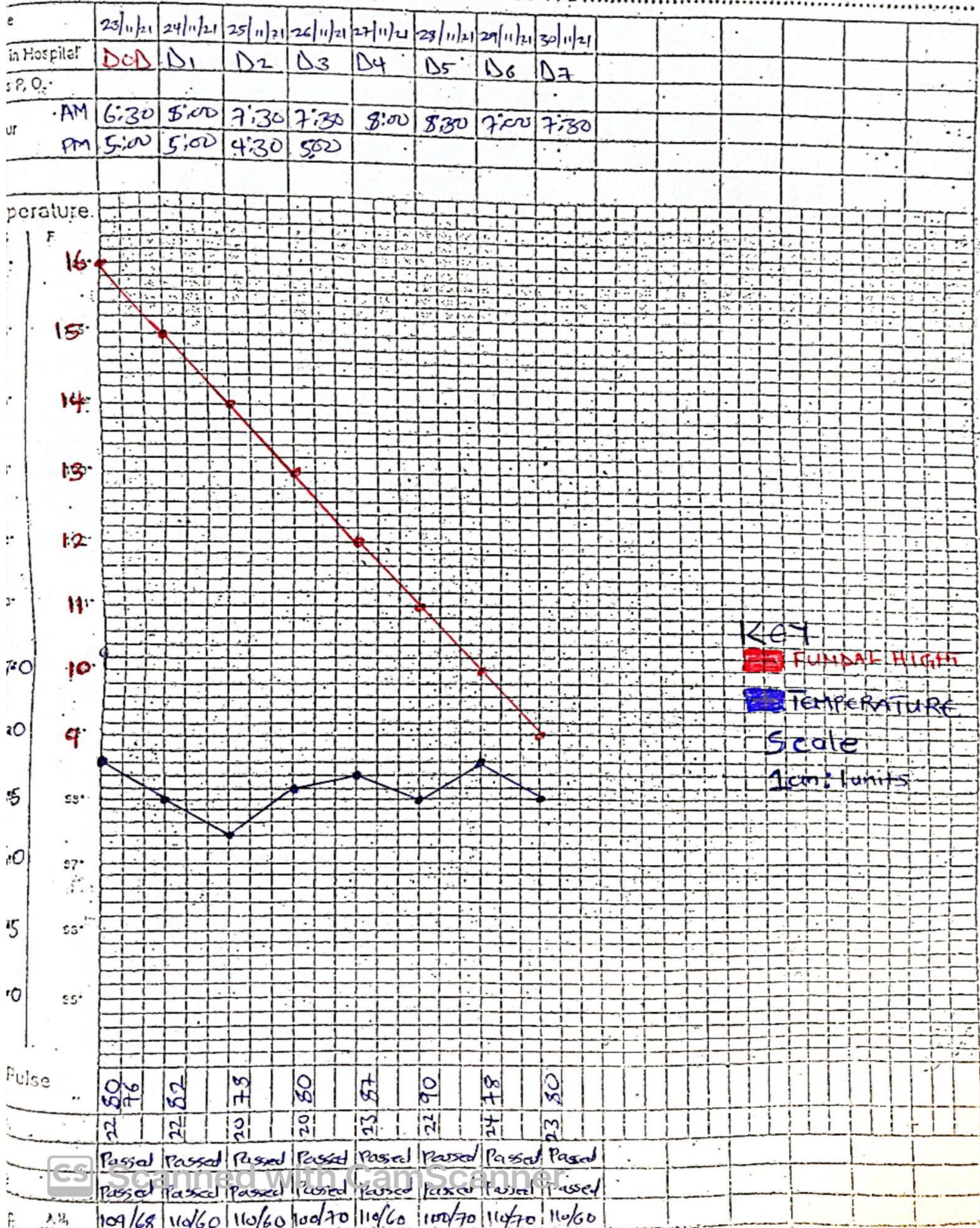
MATERNITY CHART

: Kyeraa Benedicta

: 21

: 4893/18 WARD: Lying-In

BED NO.:



e	23/11/21	24/11/21	25/11/21	26/11/21	27/11/21	28/11/21	29/11/21	30/11/21
in Hospital	DOD	D1	D2	D3	D4	D5	D6	D7
s P. O.								
ur AM	6:30	8:00	7:30	7:30	8:00	8:30	7:00	7:30
PM	5:00	5:00	4:30	5:00				
Pulse	80 76	82	78	80	87	90	78	80
	22	22	20	20	23	22	24	23
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P.	109/68	110/60	110/60	100/70	110/60	100/70	114/70	110/60

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NEW BORN EXAMINATION FORM

Baby Abena Kyeraa Date of Assessment: 23/11/2021 Time: 6:11ar

f Birth: 23/11/2021 Time of Birth: 6:00am Sex: [ ] M [✓] F Age at time of Assessment (days/hrs) ______

nal Age [ ] 40 [ ] Mode of Delivery: [✓] Vaginal Assisted Vaginal C-Section

R: 1min 8/10 5min 9/10 Birth Weight: [3.1] kg [ ] Length: 46 cm Head Circumference: 34 cm

rature at time of Assessment: 36.7 °C Urine passed: Yes No Meconium passed: Yes No

of Assessor (Midwife/Doctor): Prade Anita

piration
44cpm
: < 30 b/m *
: < 60 b/m *
60 b/m
actions *
nting *
dor *

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taneous symmetric
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uced/Absent Movement in
limb *
Movement

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eased *

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k body but blue hands/feet
e all over *
*
ndiced *

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mal
l] *
nt *

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: 160
- [ ] 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
- [✓] None
- [ ] Suction/stimulation
- [ ] Bag and mask
- [ ] Endotracheal Tube
- [ ] Ventilator/CPAP

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

indicate severe disease that requires urgent referral

oses (if known) ______

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

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

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NEW BORN EXAMINATION FORM

Name: Baby Abena Kyeraa Date of Assessment: 24/11/2021 Time
Date of Birth: 23/11/2021 Time of Birth: 6:00am Sex: [ ] M [✓] F Age at time of Assessment (days/hrs
Astational Age [ ] 40 [ ] Mode of Delivery: [✓] Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: [ ] 3.0 kg [ ] Length: 46 cm Head Circumference: 34
Temperature at time of Assessment: 36.3 °C Urine passed: Yes No Meconium passed: Ye
Name of Assessor (Midwife/Doctor): Prode Anita

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
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- [ ] Wide (>5cm)*

11. Eyes
- [✓] Normal
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- [ ] 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: 142
- [ ] 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 teste
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other:

Female Genitalia
- [✓] Normal
- [ ] Fistula(meconium/u through abnormal o vagina) *
- [ ] Large clitoria *
- [ ] Other:

24. Anus
- [✓] Patent
- [ ] Imperforate*

25. Resuscitation pi
- [✓] None
- [ ] Suction/stimulation
- [ ] Bag and mask
- [ ] Endotracheal Tube
- [ ] Ventilator/CPAP

26. Services provided
- [ ] Vitamin K1 given
- [ ] Eye care provided
- [✓] Cord care provide
- [ ] Breastfeeding initi
- [✓] Breastfeeding esta
- [ ] Immunization (BC
- [ ] BCG [ ] Polio Im
- [✓] Antibiotics in mot
- [ ] Antenatal corticos

***May indicate severe disease that requires urgent referral**

Diagnoses (if known)

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

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

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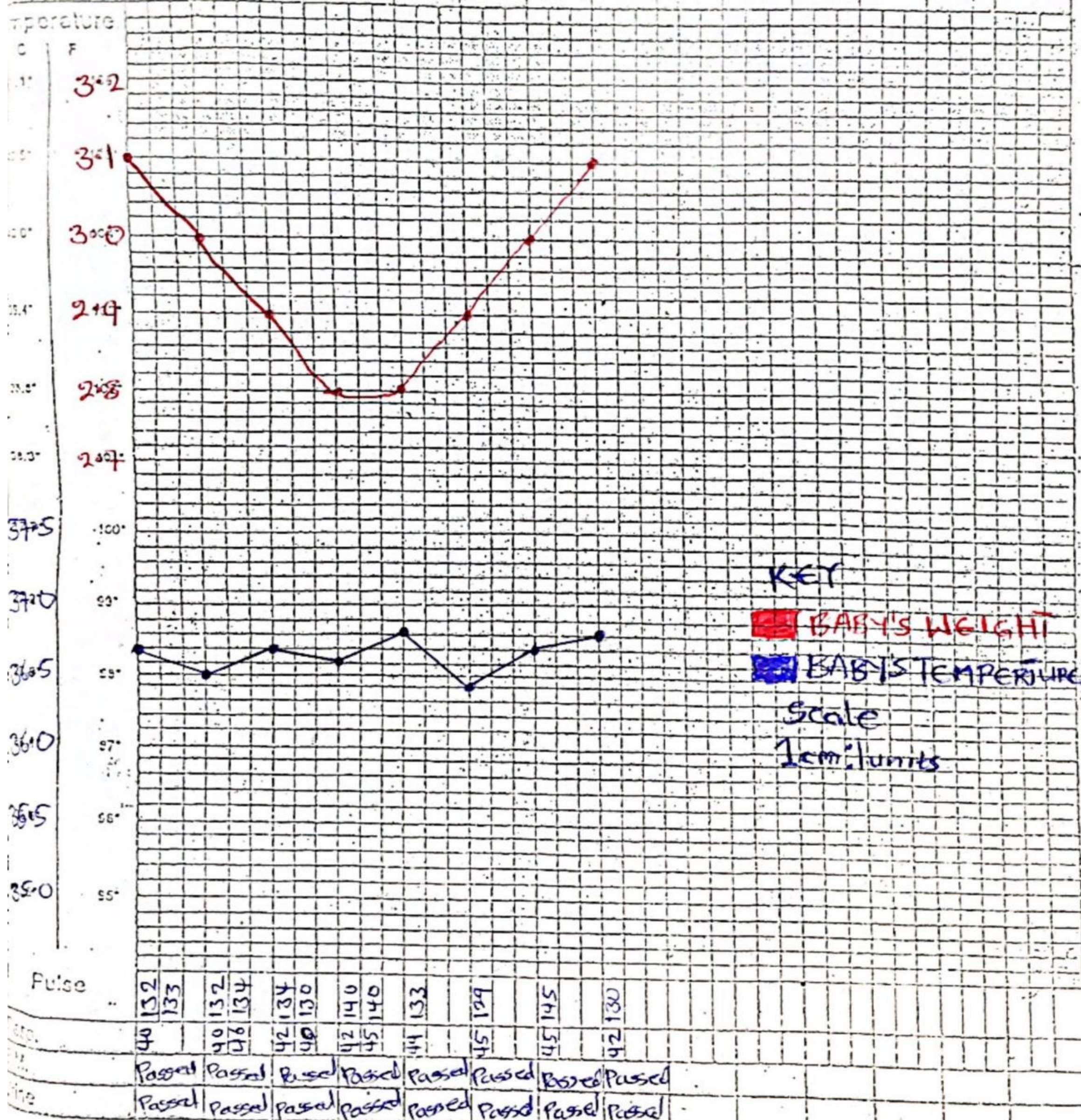
TEMPERATURE CHART

...: Baby Abena Kyeraa

New Born .... WARD: Lying - In

...: 4893/18 .... BED NO.: ....

...te	23/11/21	24/11/21	25/11/21	26/11/21	27/11/21	28/11/21	29/11/21	30/11/21
...s in Hospital	DoD	D1	D2	D3	D4	D5	D6	D7
...y P.O.								
...our AM	6:11	8:00	7:30	7:30	8:00	8:30	7:00	7:30
PM	5:00	5:00	4:30	5:00				



Pulse	132 / 133	132 / 134	134 / 130	140 / 140	133	129	145	130
...sp.	40	40 / 46	42 / 40	42 / 45	44	45	45	42
...	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
...ine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
... R. AM								

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Name: Baby Abena Kyeraa .... No: 4893/18 .... Birth Weight: 3.1 kg

Sex: Female .... Mother's No: 4893/18 .... Length: 46cm

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

Date of Birth: 23/11/2021 .... Time: 6:00 am .... Date of Discharge: 24/11/2021

Date	23/11/2021		24/11/2021		25/11/2021		26/11/2021		27/11/2021		28/11/2021		29/11/2021		30/11/2021							
No. of Days	DOD		D1		D2		D3		D4		D5		D6		D7							
Weight	3.1 kg		3.0kg		2.9 kg		2.8kg		2.8kg		2.9kg		3.0kg		3.1kg							
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
Temperature	36.7°c	36.6°c	36.5°c	36.8°c	36.7°c	36.4°c	36.6°c	36.4°c	36.8		36.4		36.7		36.8							
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
Truck
Genitalia
Lower limbs
→ No Abnormalities Detected (NAD).

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SIGNATORIES

CANDIDATE NAME

NAME: PRADE ANITA

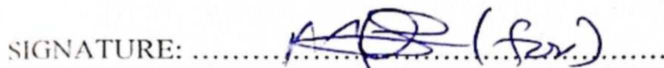
SIGNATURE:

DATE: 5 - 10 - 2022

THE MIDWIFE IN- CHARGE

NAME: MS MERCY COFFIE

SIGNATURE:

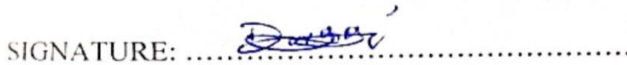


DATE: 6 - 10 - 2022

SUPERVISOR

NAME: MS DORCAS OSEI

SIGNATURE:



DATE: 7th October, 2022

THE PRINCIPAL

MS MONICA NKRUMAH

SIGNATURE:

DATE: 10 - 10 - 2022

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

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