HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT / FAMILY CENTERED MATERNITY CARE STUDY ON

KAFISKA ANUDIA

BY

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4122210120

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 MIDWIFE

(DIPLOMA)

AUGUST 2023

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PREFACE

Midwifery is a very vital aspect of health care given to the pregnant women and their families. Client and Family centered maternity care study is a systematic, comprehensive and holistic approach used in rendering obstetric care to the expectant mother and her family as a whole throughout pregnancy, labor and puerperium. The case involves data collection, nursing diagnosis, assessment, identification of problems, planning; implementation and evaluation of the data that would help solve the individual's problems.

The care also focuses on the mother's physical, emotional, spiritual, psychological and social needs to help attain maximum standard of care. The family centered maternity care study also gives the student midwife an opportunity to use her knowledge and skills acquired both practically and theoretically during her period of training to care for a pregnant woman throughout pregnancy, labor and puerperium.

Moreover, the family centered care study helps the student midwife to use the new trend in midwifery like the partograph and nursing process in management of first stage of labor and to diagnose any complication during pregnancy. The nursing process provide framework for solving problems and making decisions in the management of the client and family in a systematic manner. The study also enables student midwife to educate the client and family and also promote cordial relationship between the student midwife, the mother and her family. Furthermore, the study helps the student midwife to put into practice the concept of safe motherhood initiative which has been adapted to render quality maternity care through antenatal, labor and puerperium which will eventually reduce maternal and neonatal mortality. The family centred maternity care study is an academic exercise required by the Nursing and Midwifery Council of Ghana so as to enable the student midwife to practice after completion of her training.

ACKNOWLEDGEMENT

My first and most grateful gratitude goes to God Almighty for giving me his strength, guidance, protection and knowledge to write this case study successfully.

I am also most grateful and appreciative to the stuff of Holy Family Nursing and Midwifery Training College, Berekum for their support and encouragement they gave me during the period of my training and writing of this case study, more especially my supervisor Martha Kyeremaa for her advice and strict supervision. Again, I want to thank the Principal, Monica Nkrumah for her motherly love, care, support and strict supervision in the upbringing of this piece.

Also, my gratitude goes to my client, Madam Kafiska Anudia and her entire family for providing me with all the necessary information, co-operation and hospitality during my time of visit to their home.

Furthermore, I wish to express my gratitude and heartfelt appreciation to all the staffs of ARMS Hospital, Techiman most especially midwife in-charge, Mrs. Grace Yeboah and all the other staffs for their maximum support given to me throughout my care study. To the entire Tutorial staff of Nursing and Midwifery Training Collage, Berekum, I wish you all well in everything for your hard work and sacrifice exhibited in writing this care study.

Also, gratitude goes to the couples who gave birth to me Mr. Obeng Augustine and Mrs. Achiamaa Angelina; I say may the good Lord bless them in his own way for encouragement, also remembering me in prayers and given me the necessary support physically, emotionally and financially throughout my years of study I say God bless you abundantly.

Finally, my profound gratitude and sincerity goes to all the authors of books and references used in the study I say thumps up and bravo

INTRODUCTION

This Client and Family Centered Maternity care study was on Madam Kafiska Anudia, a 24years old, Gravida 2 Para 1 all alive and her family who live at Aworowa. Client was first met on 7th November,2022 at 37th weeks of gestation and in good health. She went through pregnancy, labor and puerperium successfully and delivered a healthy baby girl on the 20th November,2022. Mother together with her baby was discharged on the 20th November,2022. To maintain confidentiality, she will be called Madam kafiska throughout the study. The client was visited at home on several occasions and the entire family as well were included in the care. Her condition and that of the baby were stable and good at the end of the study and both mother and baby were handed over to the midwife in-charge for continuity of care. This study is made up of four chapters namely, chapter one, chapter two, chapter three and chapter four.

Chapter one deals with the particulars of the client that is her personal and social history, family history, medical history, surgical history, menstrual history, lifestyle and hobbies as well as her past and present obstetric histories.

Chapter two deals with the antenatal care of the client, a description of the first encounter with the client and home visit made to her. The nursing care plan used in providing care for the client, where problems were identified, objective set, then an implementation plan used in rendering services.

The third chapter gives report on the admission and management of the first to the fourth stage of labor, including the immediate and subsequent care of the baby and the nursing care plan.

Chapter four gives an account of the management of puerperium with emphasis on care of the mother and baby from day of delivery to the first seven days after delivery and second postnatal clinic visits.

The script also includes summary, conclusion, bibliography, appendix like laboratory investigations, antenatal records, pharmacology of drugs and signatories.

LITERATURE REVIEW

This literature review gives detailed information about what various authors and publishers says about pregnancy labor and puerperium.

PREGNANCY

According to Jacob (2013), pregnancy is the state of a female after conception and until the termination of gestation. Conception is the act of conceiving – the implantation of a blastocyte in the endometrium.

Tiran (2015) defines pregnancy from conception to delivery of a fetus; normal duration is 280 days (40 weeks or 9 months and 7 days, counted from the first day of the last normal menstrual period to delivery or 265 days from conception to delivery.

Verralls (2011) also says that the placenta also produces human chorionic Gonadotropin hormone which stimulates the ovaries continuously to produce high level of estrogen and progesterone needed to maintain the pregnancy.

LABOUR

According to Tiran (2015) labor occurs spontaneously between 37 to 43 weeks gestation with a vertex presentation of a single fetus and is completed within 24 hours without maternal or fetal trauma.

Also, Ojo and Briggs (2013) define labor as the process by which uterus empties its contents after the 28th week of pregnancy.

According to Oduro-Kwarteng (2015) labor is the process by which the fetus and all the products of conception (placenta, membranes and liquor amini) are expelled through the birth canal. This is characterized by regular painful contraction lasting at least 20 seconds (timed by a trained observer occurring at frequency of at least two contractions in every 10minutes and with a cervical dilatation of at least 3cm.

According to Fraser and Cooper (2014), Labor is the process by which viable fetus, placenta and membranes are expelled through the birth canal, they described it`s onset as spontaneous and the presenting part being the vertex which is normal presentation.

They continued to talk about labor being in three stages.

The first stage is the onset of regular rhythmic uterine contraction and finally culminates in complete effacement of the cervix. The latent phase is prior to active first stage of labor and may last 6-8 hours in the first time mother`s cervix dilates from 1cm to 4cm dilation.

Active first stage is the time when the cervix undergoes more rapid dilatation. This begins when the cervix is 3cm to 4cm dilatation in the presence of rhythmic contraction and is complete when the cervix is fully dilated (10cm). The partograph is used during this stage to monitor the progress of labor, maternal condition and fetal condition to detect any deviation from normal for prompt action.

The second stage is the expulsion of the fetus. It begins when the cervix is fully dilated. In psychological labor, the woman usually feels the urge to expel the fetus and complete when the baby is born. The first stage of labor is the period from the onset of regular uterine contractions to full dilation of the cervical OS. It lasts 12-14 hours in primi gravida and 6-12 hours in multigravida. The first stage of labor comprises of;

Painful uterine contraction,

Progressive dilation of the cervix,

Formation of the fore waters

Rupture of the membranes.

The second stage of labor starts from the full dilation of the cervical OS to the complete expulsion of the baby. It lasts about one hour in a primigravida and 5-30minutes in a multigravida. Strong uterine contractions, descent of the head through the pelvis, and the birth

of the child are the features of the second stage of labor entails complete expulsion of the placenta and membranes, usually within 5-15 minutes of the birth of the infant.

The other feature of the 3rd stage, apart from the detachment and expulsion of the placenta, is the control of bleeding.

The third stage is the separation and expulsion of the placenta and membranes. It starts from birth of the baby until the placenta and membranes have been expelled.

During this stage, controlled cord traction and oxytocin drug is used to expel the placenta and control hemorrhage.

PUERPERIUM

Fraser, cooper and Nolte (2014), define puerperium as the mother entering the period of physical and psychological recuperation following the birth of the baby and the expulsion of the placenta.

The genital organs and the other organs which underwent changes during pregnancy return to their pregnant state. This process of readjustment is called involution.

Oduro-Kwarteng (2015) explains puerperium as a period that start immediately after the delivery of the placenta up to six (6) to eight (8) weeks. This period is characterized by a lot physiological change.

Oduro-Kwarteng again emphasized that lactation, which is a foundation of the bonding or relationship between the mother and the baby aside the skin to skin contact is initiated.

According to Fraser and Cooper (2014) puerperium or the postnatal period is traditionally defined as the time from immediately after the end of labor until the reproductive organs have returned as early as possible to their pre-gravid condition, a period estimated to be around six (6) to eight (8) weeks, although the evidence to support this duration is lacking.

The overall expectation is that by six (6) weeks after birth, all the systems in the woman's body would have recovered from the effects of pregnancy and return to their non-pregnant state. Veralls (2011) defines puerperium as the period 6-8 weeks following child birth during this time the genital organs return to their pre pregnant state, lactation should be established and the new infant should be accepted into the family.

WHY CLIENT WAS CHOOSEN

On 7th November,2022 which was Monday at 9:30am Madam Kafiska Anudia was met at ARMS Hospital at the Antenatal care unit coming for an Antenatal visit.

My first contact with her started in the antenatal consulting room when it was her turn to be attended to. After head-to-toe examination was done, I inquired from her if she had any problems pertaining to the pregnancy which may require a midwife's or doctor's attention. It was then she complained of her delayed onset of labor.

According to her, she was worried and so anxious about her delayed onset of labor because she was in her 9th month and from the antenatal records, she was in her 37th weeks of gestation and the scan gave her estimated date of delivery as 24th November, 2022. Based on the information client gave.

I asked of her last menstrual period which was on the 12th February, 2022 and I calculated her expected date of delivery to be 19 November, 2022. I explained to her the normal duration of pregnancy which starts from thirty-seven to forty weeks (37-40 weeks) starting from the last menstrual period.

I also told her the true sign of labor which include; true labor commencing with uncomfortable contraction, slight at first but increases severity and frequency later.

It occurs at regular intervals. The cervix dilates as a result of contraction which is rhythmic in nature. There is "show" that is the discharge of ternicious mucus (Operculum) mixed with streaks of blood.

Client was reassured that she was in competent hands of midwife, therefore she will deliver safely. I took the opportunity to introduce myself as Obeng Kissiwaa Jessica a student midwife from Holy Family Nursing and Midwifery Training college Berekum and explain my mission

to her. She happily accepted it and promise to give me all the necessary information that would be needed.

CHAPTER ONE

CLIENTS PARTICULARS

1.0 INTRODUCTION

This chapter deals with assessment of the client. It gives information about Madam Kafiska Anudia, the client used for the study. Her family, community which constitute the social, surgical, menstrual, past obstetrical lifestyle, present obstetrical histories and the environment in which she lives.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Kafiska is 24years old and comes from Navorongo in the upper East region. She lives at Aworowa with her family. She speaks English, Twi, Grusi and Frafra. She is fair in complexion, her weight is 72kg and is 168cm tall. She completed Junior high school at Navorongo. Client's occupation is seamstress and she is married to Mr. Richard Kafiska who also does fitting works.

They have been married for five years now. Mr. kafiska is 27 years of age and lives at Aworowa. His level of education ended at the SHS. He speaks Twi, English and Frafra. He comes from Navorongo. He is dark in complexion and is 170cm tall. Her house address is AW0840, Aworowa.

Her intention was to deliver at ARMS Hospital. She is a Christian and attends church on Sunday. She has only one female child who is Two years old named Priscilla Tereyawn receiving education at shining star at Aworowa. Her next of kin is her mother.

1.2 FAMILY HISTORY

Opanin Asonre Kajonu and Madam Grace Kajonu are the parents of Madam kafiska. Her mother is a trader and her father is a farmer. She is the fourth born of six children of her parents. According to her, there are no known hereditary conditions such as sickle cell disease, hypertension, mental disorder, epilepsy, diabetes and asthma in her family. She further stated that there is history of multiple pregnancies in her family. According to her, death in her family was natural.

1.3 MEDICAL HISTORY

According to client, she has never been admitted to the hospital before Client mentioned that she sometimes experiences minor illness which is treated on Out-Patient Department basis. Client said she usually experiences malaria but does not have any condition like asthma, hypertension, diabetes mellitus, tuberculosis and among others. She has no known allergies to food and drugs. She is also not on any medication for any chronic illness.

1.4 SURGICAL HISTORY

According to Madam Kafiska, she has never had an accident that has affected her pelvis and part of her body before. She has neither undergone any surgical operation which has affected her pelvis, spine nor reproductive organ. She also said she has never received blood transfusion or donated blood before.

1.5 MENSTRUAL HISTORY

According to client, she has a thirty (30) days menstrual cycle and bleeds for seven (7) days. She had her menarche at the age of thirteen (13) and since had a regular menstrual flow with no dysmenorrhea. She uses sanitary pad during her menstruation and she changes it at least

twice a day. It took her more than one year before she menstruated again after both deliveries. Her last menstrual period was 12th February, 2022 and her expected date of delivery was calculated to be 19th November, 2022.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Kafiska wakes up around 6am and goes to bed around 10pm. She washes her face and brushes her teeth with toothbrush and toothpaste. The next thing she does is to sweep her compound. She prepares breakfast for the family. She takes her bath, baths her daughter and prepares her for school. She prepares lunch at 12noon and prepares supper for the family around 5pm. She eats thrice daily and empty her bowel at least once a day. She neither smokes cigarettes nor takes any alcoholic drink. On Saturdays, she cleans the house with the help of her husband. Her dirty clothes as well as that of her husband and the child are washed and dried in the sun. Her favourite food is Tubaani and Tuozafi. She enjoys conversing and uses her leisure time mostly to sleep. On Sunday, she goes to the church with her family and closes around 01:00pm. She goes to the market every Wednesday (which is a 'market day') to buy foodstuffs in bulk and shops for the items that she would need in the upkeep of the house. She then comes home and prepares food for her family.

1.7 PAST OBSTETRIC HISTORY

Pregnancy

Madam kafiska, gravida 2 para1, alive, went through her pregnancy without any illness and had a term pregnancy. The interval between the first and second pregnancy was Two years. There were no complications like ante partum hemorrhage. She said she has had three doses of tetanus -diphtheria injections during her first and second pregnancy and had all the doses of

Sulphadoxine pyrimethamine as prophylaxis against malaria. She was a regular attendant to antenatal care until she delivers.

Labor

She had spontaneous vaginal delivery to an alive female child at Aworowa health center, Techiman-south and she weighed 3.5kg. The baby cried as soon as she was delivered. The third stage were actively and properly managed without any complication. She further mentioned that she had no history of retained placenta and the perineum was intact. In the fourth stage, the condition of the mother and the baby were good. She had no postpartum hemorrhage.

Puerperium

Madam Kafiska puerperal period according to her was normal. She had no puerperal psychosis; sub-involution and she visited the postnatal clinic as scheduled. She and her baby were healthy throughout. She practiced excusive breastfeeding for Three (3) months and combine supplementary feed like corn dough, porridge and cerelac while she continues with the breastfeeding till the child was two years old. According to Madam Kafiska her child received the immunization against childhood preventable diseases. She received support from her husband and her mother during her previous delivery. According to her, her child has been healthy since birth. With her last child, she was unable to practice Exclusive Breastfeeding because of persuasions from her mother to introduce other local foods by three months with the excuse that the children were not getting satisfied with the breast milk alone.

She was however bent on practicing Exclusive Breastfeeding.

She continuously breastfed for 2years before she completely took her away from the breast.

On the issue of family planning, Madam Kafiska was on the calendar method which she claimed failed her and resulted in her recent pregnancy. she had always been supported by her husband and a family friend who stays closer to her during puerperium

1.8 PRESENT OBSTETRIC HISTORY

Madam Kafiska G2 P1 visited the antenatal clinic at an early age of the pregnancy on 12weeks of gestation at Aworowa Health Center. Client gave her last menstrual period to be 12th February,2022. Her expected date of delivery was calculated to be 19th November,2022 and her gestational weeks at booking was twelve weeks

On her 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 - 11.0g / dl

Sickling Test - Negative

Blood group - O

Rhesus factor - Positive

G6PD - Negative

VDRL - Negative

HIV status - Negative

Urine R/E - No abnormalities detected

Stool R/E - No abnormalities detected

The following observations were made and recorded;

Temperature	-	36.1o C
Pulse	-	80bpm
Respiration	-	20cpm
Blood Pressure	-	107/50mmHg
Hepatitis B Status	-	Negative

Other measurements were taken as follows:

Weight - 72kg

Height - 168cm

Records on her antenatal card indicated that she was examined from head to toe and no abnormalities were detected. On abdominal examination, no abnormalities were detected and symphysio-fundal height was not palpable. She had no complaints; therefore, she was served with the following routine drugs;

Folic acid 5mg (1 daily) for 30 days

Tablet Fersolate 200mg (1daily) for 30 days

Tablet Multivitamin 200mg (1 daily) for 30 days

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 7th November,2022 when she was 37 weeks pregnant.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter is about the care given to client during pregnancy specifically from the 37th week. 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.

2.1 FIRST CONTACT WITH CLIENT

Madam Kafiska was met on 7th November,2022 at ARMS Hospital during the antenatal day when she was 37weeks pregnant. It was her 8th visit to the hospital. This woman was approachable and ready to share any information. Introduction was made as Obeng Kissiwaa Jessica, a student midwife from Holy Family Nursing and Midwifery Training College, Berekum, on seven weeks placement for community centered midwifery. Her antenatal book was collected and found out that she fell within the criteria and she has been attending antenatal clinic regularly and has no abnormal condition which can be a threat to her pregnancy. Brief information was given to her about the care study and why she was chosen and she accepted it and pledged her full support and co-operation. She was then taken through the general examination when it got to her turn with procedures explained. She was encouraged to ask question. Her vital signs were checked and recorded as follows;

Temperature - 36.4OC

Pulse - 78bpm

Respiratory rate - 20cpm

Blood pressure - 122/67mmHg

Other observations made were recorded as follows;

Weight - 78kg

Height - 168cm.

URINE TESTING

The client was given a clean container to void into it. It was explained to her that midstream urine was needed. Hand was washed and dried with a clean towel and protective cloths worn. Chemically prepared strip was dipped into the urine and compared to the readings on the strip container to exclude the presence of glucose, protein, ketones etc. which all proved negative.

All these findings were recorded in client's antenatal record booklet with findings explained to her. After the above procedures, education was offered to her on the following; warning signs in pregnancy like bleeding per vaginum, and losing of liquor, budgeting and layette, signs of impending labor, taking of medication as prescribed and, sleeping in an insecticide net to prevent malaria and good nutrition.

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 the supervision of the midwife in-charge.

PHYSICAL EXAMINATION

Head And Neck.

After cleanliness checked on the hair, there were no dandruff, lice, ringworm, loss of hair, scalp infection and no abnormalities were detected. Client was congratulated for keeping the hair clean and was encouraged to keep it up.

The face was inspected for acne, chloasma, oedema and rashes but no abnormality was detected. The ears were inspected and there were no discharges. The eyes were inspected for jaundice of the sclera, pallor of the conjunctiva, alignment with the ears and discharges but

nothing abnormal was detected. Also client lips were inspected for pallor, dryness, lesions, sores and mouth for tooth decay, loss of teeth and halitosis but no abnormality was detected. Madam Kafiska's neck was also checked and palpated. Suitably there was no enlarged thyroid gland, lymph gland and no distended neck vein or lumps.

Breast Examination

The breast was exposed to check for size, shape, signs of pregnancy, dimpling and nipple retraction and condition of the skin. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self-examination. She was advised to examine her breast regularly for early detection and reporting of any abnormalities. Nipples were squeezed gently for fluid (colostrum) and were cleaned with cotton wool swab, and were examined for odor and blood. The same was done for the other breast and no abnormality was noted. Breastfeeding history was asked and her desire to breastfeed was positive as her children were breastfed.

Extremities

The upper extremities were examined for equality and alignment with the body but both were equal. The hands and fingers were also examined for dirt and grown nails, oedema, pallor of palm and nail bed and all these were absent. Capillary refill of the finger nails was checked by pressing the nail bed and releasing it and the result was good. Client was therefore congratulated and encouraged to continue with her cleanliness. The lower extremities were examined for size and equality, varicose veins and oedema as well as leg cramps, tenderness in the calf muscle but no abnormalities were detected.

Back

Client was assisted to turn her back for inspection and upon inspection and palpation of the sacral region no lesion or oedema was detected. There was no costovertebra angle tenderness.

Abdominal Examination And Palpation

Position And Procedure: To further reduce inaccuracies, client was assisted to lie in a recumbent or dorsal, with her knees bent and arms by her side to relax the abdominal muscles. Hands were washed with soap and water and dried with a clean dry towel. Standing on her right side, the abdomen was exposed. Before examination, palms were rubbed together to provide warmth to prevent induced contraction. And eye contact was maintained.

Inspection: On abdominal inspection, the shape of the abdomen was ovoid, medium in size and there was presence of linear nigra but no striae gravidarium. The abdomen was inspected for scars from previous delivery and there was none detected and fetal movement was present.

Measurement of symphysio-fundal height: Hands were warmed, the upper symphysio-fundal height measured 36cm and gestational age was 37weeks.

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 fetal buttocks.

Lateral palpation: Lateral palpation assesses the main body of the uterus to confirm the lie and identify the fetal position. This was done with palms on both sides of the uterus midway between the symphysis pubis and the fundus; the uterus was stabilized with a hand. Also, palpation was done through the entire midline to the lateral side of the abdomen to locate the fetal back in a rotary manner. The other hand was also used to stabilized the uterus and the procedure was repeated for the other half of the abdomen. The right lateral palpation was done at the right side of the woman and a smooth part was felt, which indicated the fetal back, which will help to position the fethoscope to listen to the fetal heart rate and the fetal limbs. Lastly, rough part was located on the left side of the mother. The position was right occipito anterior.

Pelvic palpation: the client was asked to flex her legs slightly and breathe through her mouth. 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, the head was palpated.

The lie therefore was longitudinal, presentation was cephalic and the position was right occipito-anterior.

Descent of the head: Location of the anterior shoulder was made and two fingers were placed on it. The symphysis pubis was located and the right ulna border was placed just above the symphysis pubis and the anterior shoulder. Five fingers occupied the space indicating decent of 5/5.

Auscultation: On auscultation, the fetal stethoscope was warmed by rubbing in the palm and placed at the area where the fetal back was located to listen to the fetal heart rate. With one hand at the maternal radius to ensure that it is not the maternal pulse being listened to, the fetal heart rate was checked for one minute and recorded as 148beat per minute.

Vulva and perineum: Permission was sought to examine the vulva and it was granted. Hands were washed under running water with soap and dried with a clean towel and gloves were put on. The mons pubis was well shaved; there were no scars, varicose veins and genital warts. 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 advised 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 into 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 baby descending 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 as a result of the fetal head descending into the pelvic cavity 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 labor were explained to her. That was first, second, third and fourth stages," show" and painful rhythmic uterine contractions. She was advised to report to the clinic if she sees any.

She was served with routine drugs as below;

Tab Fersolate - 200mg daily for 30days.

Tab Multivitamin - 5mg daily for 30days.

Tab folic acid - 200mg daily for 30days.

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 the next day that is on the 8th November,2022. She was thanked and was escorted to pick a car.

2.2 FIRST ANTENATAL HOME VISIT

First home visit to Madam Kafiska´s house was on the 8th November,2022 at 5:00pm. The main aim was to know where she lives and meet other members of her family and also talk about birth preparedness and complication readiness plan. The journey was made by car to the client's house by the directions given by her. The house was a little far from the facility. It was located at the outskirt of the town. She was very glad for the visit. A warm welcome and seat was offered. A glass of water was served after that interaction with her started. Introduction was made to the family.

PHYSICAL ENVIROMENT

A quick assessment of the environment was done. Her child by then were playing on the compound. Client lived in a boys quarters. The house was built with blocks and roofed with aluminum sheets. There were 3rooms, well arranged kitchen and toilet and bath. They had an uncompleted room attached to the where the kitchen is. Outside the house is painted with green

color while inside of her room is painted with green and white color. Client and her husband have their room. The other two rooms had been occupied by her mother and father who has come to visit and her younger sister who help her with the house chores respectively. Their surroundings were neat and they have planted some crops. Behind the house they have dig a hole where they empty their refuse and burn it on weekends. The used water from the bathroom drains through a pipe and goes into a gutter that is close by.

They have a bole hole in which they fetch water from and have electricity as a source. They use "Akina" sachet water as their drinking water. Water used for other purposes such as cooking, bathing, washing is stored in a brown colored barrel covered with a lid. Layette was brought for inspection and it was complete. She was congratulated for purchasing all the items and was advised to add her National Health Insurance card, ANC card and take money along.

As the interaction continued, she was 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 encouraged to keep up on her environmental hygiene. Her mother arrived just as the discussion was about to be concluded. She was advised to give a helping hand to the client to reduce tiredness and promote adequate rest and sleep. Her mother was advised to help in caring for the child. She was informed about the next visit which was on the 11th November,2022 Permission was sought to leave. She was very grateful. She was thanked for her co-operation and willingness to heed the advice out.

2.3 PSYCHOSOCIAL ENVIRONMENT

Madam Kafiska, the husband, the child and family have a cordial relationship with each other, She has a warm and friendly relationship with her neighbors, other family members staying around the house. Her friends most of the times visit her and she also visit them at her leisure

time. She is very free and likes to crack jokes. She has respect for humans and likes to make new friends.

After all interactions, Madam Kafiska and her family were then appreciated for their warm reception and permission was sought to leave. The next scheduled and then seen off by client.

2.4 SECOND ANTENATAL HOME VISIT

On the 11th November,2022 at 2:30pm, Madam Kafiska was paid a visit as she was promised. A cheerful welcome was given by client. Client's husband was met, they were all happy. After exchange of pleasantries, she complained of constipation and frequency of micturition but was reassured and the physiological change in pregnancy was explained to disappear after delivery. Client was reminded on the true signs of labor and education was given to her to have enough rest and sleep, intake of fluid and nutritious food. She said her husband was being helpful in performing the household chores since the first visit. Discussions was made about postpartum family planning and her husband said that they were interested in it.

2.5 SUBSEQUENT VISIT TO THE HOSPITAL BY THE CLIENT

She reported to the hospital on 14th November,2022 at 7:30am as scheduled. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows;

Temperature	-	36.0oc
Pulse	-	80bpm
Respiration	-	21cpm
Blood pressure	-	110/60mmHg

Other investigations were recorded as follows;

Haemoglobin	-	10.8g/dl

Weight - 76kg

Client was asked to empty her bladder; midstream urine sample was tested for protein and sugar and it was negative. She 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 was 38weeks, 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 136bpm with regular rhythm and good volume. Client complained of visible vaginal discharge which was explained to her as leucorrhea after inspection. All findings were communicated to her and recorded in her antenatal card.

2.6 NURSING CARE PLAN DURING ANTENATAL CARE

Nursing care plan is a 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 that will 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 Kafiska that were for antenatal, labor, and puerperium.

PROBLEMS IDENTIFIED DURING ANTENATAL CARE

On 7th November,2022.; Client complained of

1. Lower abdominal pain

2. Waist pain

On 14th November,2022

Client complained of

3. Constipation.

4. Vaginal discharge (leucorrhea).

5. Frequency of micturition

SHORT TERM OBJECTIVES

1. Client lower abdominal pains will be relieved and maintained throughout pregnancy.

2. Client waist pains will be minimized within 24hours

3. Client will have her normal bowel movement once a day within 24hours

4. Client will cope with vaginal discharge till the end of pregnancy.

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

LONG TERM OBJECTIVE

Client will go through pregnancy, labor and puerperium successfully without any complications to both mother and fetus

TABLE 1. NURSING CARE PLAN FOR ANTENATAL CARE

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
7/11/22 at 5:00pm	Impaired body comfort (Lower abdominal) pains related to descent of fetal head.	Client will cope with reduced lower abdominal pains within 48 hours as evidenced by midwife observing client complains less of the pain.	1. Reassure client that her pains would, subside after delivery. 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's 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 help client with household chores like washing and sweeping	09/11/22 at 6:00pm	Goal partially met.	JOK

ANTENATAL CARE PLAN CONTINUES

DATE TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
7/11/2022 5:00pm	Pain (waist) related to hormonal influence of progesterone on the pelvic ligament.	Client`s waist pain will be minimized within 24 hours as evidenced by client verbalizing that the pain is minimized.	1. Reassure client that pain is physiological and will be minimized with correct coping measures. 2. Educate client on the physiology behind the waist pain. 3. Educate client not to stand for a long time. 4. Encourage client on wearing of low heel shoes. 5. Educate client on rest and sleep.	1. Client was reassured that the pain will be minimize with correct coping measures. 2. She was educated on the physiology behind the waist pain. 3. Client was educated not to stand for a longer time. 4. Client was encouraged on the wearing of low heel shoes. 5. Client was educated on rest and sleep during day and night.	8/11/22 5:20pm	Goal fully met.	JOK

ANTENATAL CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
14/11/22 at 2:30pm	Alteration in bowel movement (Constipation) related to progesterone causing decrease peristaltic movement of the bowls and relaxation of the smooth muscles of the intestine.	Clients will regain her normal bowel movement once daily as within 24hours evidenced by; 1. Client verbalizing that she is able to empty her bowel freely. 2. Client husband verbalizing that his wife can empty her bowel freely.	1. Reassure client to allay fear and anxiety. 2. Explain the physiology behind constipation. 3. Educate client on the intake of food rich in fiber. 4. Encourage client to take a lot of fluids every day. 5. Encourage the client to engage in tolerable exercises such as walking.	1. Client was reassured to allay fear and anxiety. 2. The cause was explained to client that it is as a result of smooth muscle relaxation by progesterone during pregnancy. 3. Client took food rich in fiber like oranges, banana. 4. Client drank eight glasses of water per day. 5. Client understood the health benefits of exercising and engage herself in walking.	15/11/22 at 2:40pm	Goal met.	JOK

ANTENATAL CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
14/11/22 at 2:30pm	Vagina discharge related to increased vascularity and mucus production of the genital during pregnancy.	Client's will understand the physiology and management of vagina delivery within 48hours as evidenced by client: 1. Verbalizing that amount of vaginal discharge has reduced. 2. Midwife observing client complains less.	1. Reassure client that the discharge will stop after pregnancy/ delivery 2. Explain the physiology of vagina discharge to client. 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 her panties in the sun if possible.	1.Client was reassured that the discharge will reduce. 2. Physiology of vagina discharges was explained to client. 3. Client wore cotton panties. 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 to reduce the rate of infection when it was possible.	16/11/22 at 3:00pm	Goal fully met.	JOK

ANTENATAL CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
14/11/22 at 2:30pm	Frequency of micturition related to the growing uterus exerting pressure on the bladder	Client will understand the reason for the micturition and cope with the condition within 72 hours after as evidence by client verbalizing: She is able to cope with the frequency of micturition and understand about the condition and Midwife observing that client complains less of the frequent voiding.	1.Reassure client. 2. Encourage her to lean forward when voiding to help empty her bladder. 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.	1. Client was reassured and reminded of the frequency of micturition. 2. She leaned forward when voiding. 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.	17/11/22 at 3:00pm	Goal fully met.	JOK

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about labor, admission and management of the various stages of labor, the immediate care of the new-born, examination of the new-born and care plans drawn for the management of the problems encountered during this period.

3.1 ADMISSION AND MANAGEMENT OF LABOUR

Madam Kafiska reported to the facility with her husband on 20th November,2022 at 1:00am which was Sunday with complain of lower abdominal pains. 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. Labor history was taken and according to her, she experienced severe lower abdominal pain and has seen show at 9:00pm. It 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 due to discomfort. 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.

Client vital signs were checked and recorded as follows;

Temperature - 36.1°C

Pulse - 83bpm

Respiration - 24cpm

Blood Pressure - 120/70mmHg

Other observation recorded as

Hemoglobin - 12.3g/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 color 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 38cm, and gestational age was 39weeks, the lie was longitudinal, presentation was cephalic and descent was 3/5th palpable abdominally. Contraction was 3 in 10 minutes lasting for 30 seconds.

Auscultation: The heart rate was 128 beats per minute with good volume and regular in rhythm.

Vaginal Examination: Madam Kafiska was helped onto the lithotomy position at 1:30am 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 four (4) 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. Hands were removed and a fist was made and it fitted into the intertuberous diameter. Madam Kafiska 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. Client was encouraged to lie on her left side when she felt tired. 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 labor and findings were recorded on the labor 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 labor. 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 was offered a seat outside and he was reassured of safe delivery.

3.2 PREPARATION FOR BIRTH

Identification of helper and review of the emergency plan: The midwife in-charge who was supervising labor 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 Kafiska 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 Kafiska'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 equipment 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.

3.3 MANAGEMENT OF FIRST STAGE OF LABOUR

Client was put on partograph on admission when labor was established fetal heart rate, contractions and pulse was checked every 30 minutes and vaginal examination, descent, blood pressure and temperature was done 4hourly. 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 labor. 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 color of urine was amber, clear and not offensive.

At 2:00am fetal heart rate was 130bpm, contraction was 3⁚10 lasting for 34sec, maternal pulse was 88bpm. At 2:30am fetal heart was 130bpm, contraction was 3⁚10 lasting for 36 sec,

maternal pulse was 88bpm. She was also encouraged to adopt left lateral position to prevent supine hypotension syndrome. Findings were also communicated to her. At 3:00am fetal heart rate was 138bpm, contraction was 3:10 lasting for 36 sec, maternal pulse was 84bpm. At 3:30am fetal heart rate was 136 bpm, contraction was 3:10 lasting for 38sec, maternal pulse 82bpm. Client was encouraged to empty her bladder frequently to aid in the decent of the fetal head. At 4:00am, fetal heart rate was 128bpm, contraction 4:10 lasting for 41sec maternal pulse 88bpm. At 4:30am, fetal heart rate was 130bpm, contraction was 4:10 lasting for 41sec, maternal pulse was 82bpm. At 5:00am, fetal heart rate 128bpm, contraction was 4:10 lasting 42sec, maternal pulse was 86bpm.

At 5:30am client vaginal examination repeated, cervix was 8cm dilated with descent 1/5th, contractions 4 in 10 minutes lasting for 45 seconds with membranes still intact, fetal heart rate was 132bpm. Client's vital signs was checked and recorded as follows:

Temperature	-	36.0 degrees Celsius
Pulse	-	90 beats per minute
Respiration	-	23cycles per minute
Blood pressure	-	120/70millimeters per mercury
Fetal heart rate	-	132 beats per minute
Descent	-	1/5th
Contraction	-	4 in 10 lasting for 40 and 50 seconds

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 100mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the color of urine was amber, clear and not offensive. Hands were washed with soap under clean running water and dried with clean dry towel.

All findings were communicated and recorded on the partograph and client was informed of progress of labor 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;

TOP SHELF

• 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 scissor

• Receiver

• Episiotomy set

• Cord clump

• Pair of sterile gloves

• 10 units of oxytocin

• Two cot sheets

• Vitamin k injection

LOWER SHELF

• A jug for measuring the amount of blood loss

• Receiver for placenta

• Container with syringes and needles

• Fethoscope

• Antiseptic lotion (savlon)

• Sterile gloves

• Extra perineal pad

• Small cup containing water and bulb syringe

• Cord clamp

• Bed pan

• Identification band

• Examination gloves

• Mackintosh

• Cot sheets

• Drum containing gauze and cotton wool

- Cheatle forceps in its container.

At 6:00am, fetal heart rate 138bpm, contraction was 4:10 lasting 43seonds, maternal pulse was 92bpm. Client was encouraged to perform deep breathing exercise. At 6:30am fetal heart rate 130bpm, contraction was 4:10 lasting 45second, maternal pulse was 89bpm. At 7:00am fetal heart rate 130bpm, contraction was 4:45second, maternal pulse was 92bpm. Client was encouraged to lie on the left lateral position to prevent supine hypotension and also encourage to take more fluid to prevent dehydration.

Labor progressed well, client complained that she wants to defecate. At 7:30am 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, moulding was (++) which indicated that the bone was overlapping each other but could slip off, liquor was clear, 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 labor and was asked to confirm my findings and she confirmed client was fully dilated and she was which marked the beginning of second stage of labor. Client was again reminded that her baby will be delivered unto her abdomen 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	-	92 beats per minute
Respiration	-	24 cycles per minute
Blood pressure	-	120/70 millimeters per mercury
Fetal heart rate	-	137beats per minute
Descent	-	0/5th
Contraction	-	5 in 10 lasting for 40 and 50 seconds

3.4 MANAGEMENT OF THE SECOND STAGE OF LABOUR

The second stage of labor starts from full dilatation of the cervix to birth of the fetus. 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 was 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 fetus. Client 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 chest to initiate bonding, breast feeding and to provide warmth. The baby was completely expelled at 7:40 am.

3.5 IMMEDIATE CARE OF THE BABY AT BIRTH

Immediately the head was delivered, sterile gauze was used to clean the baby's eyes from the inner canthus to the outer canthus. The baby was delivered onto the mother's abdomen. The cord was clamped 3 centimeters away from the baby's abdomen and second clamp 2

centimeters from the first clamp. The cord was covered with gauze and cut in between the clamps to separate the baby from the mother within the first three minutes. First minute Apgar score was 8/10. The baby was made warm by wiping off the liquor and was covered on mother's abdomen for skin-to-skin care. The fifth minute APGAR was 9/10. An identification band was placed on the baby's wrist.

The Apgar score assessment was as follows;

INDICATOR	**FIRST MINUTE**	**FIFTH MINUTE**
Appearance	2	2
Pulse	2	2
Grimace	1	2
Activity	1	1
Respiration	2	2
Total	8/10	9/10

3.6 MANAGEMENT OF THE THIRD STAGE OF LABOUR

She was in the lithotomy position and a receiver placed near the vulva in between the thighs. Procedure was explained to her. The uterus was palpated to rule out the presence of a hidden twin and ten (10) units of oxytocin was injected intramuscularly on the mother's thigh by the Midwife-In–Charge to aid in the contraction of the uterus and separation of the placenta. Non dominant hand was placed on the fundus to feel for contraction of the uterus. The cord was re-clamped nearer to the perineum with one artery forceps. The cord and artery forceps were held with the dominant hand. As soon as the uterus contracted, the non-dominant hand was removed and placed just above the symphysis pubis with the palm facing the abdomen of the mother to provide counter traction to prevent uterine inversion during removal of the placenta.

At the same time, the dominant hand that held the clamped cord was pulled gently in a downwards direction following the curve of carus. With steady controlled cord traction, the process was repeated until the placenta was visible at the vulva and cupped with the two hands, and was rolled round to gently tease the membranes from the lower segment. The placenta was completely delivered at 7:45am. A quick examination of the placenta was made where both the maternal and fetal surfaces were intact. The placenta was placed in a receiver for thorough examination later. The uterus was rubbed for a contraction and clots were expelled.

The client was taught how to massage the uterus. The vulva was cleaned with water, the labia were patted and cleaned. Two sterile gauzes were wrapped on the middle and index finger for inspection using the clockwise method and there were no lacerations on the perineum. The vaginal walls and cervix were inspected but there were no tears. The total blood loss was estimated as 150 milliliters. Client was cleaned and a new perineal pad was applied to the vulva to absorb any lochia and client was made comfortable in bed. Client was congratulated.

EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was dip in 0.5 chlorine and removed immediately. The placenta was examined under a good source of light and on a flat surface. The fetal surface was greyish blue with firm amniotic membranes and cord was in the center of the placenta. The maternal surface was dark red in color. It was covered with chorion which was opaque. The membranes, lobes and cotyledons were inspected and they were intact. No infarct and oedema were seen on the maternal surface, the cord was thick with Wharton's jelly. The tip of the cord was wiped with a dry cloth for inspection. It had two arteries and one big vein. The placenta was placed in 0.5% chlorine solution in the sluice room for decontamination and discarded in the placenta pit. The delivery instruments and equipment used were soaked in 0.5% chlorine solution, gloves were removed and hands were washed. After 10 minutes, instruments were removed with utility

gloves, washed in soapy water and rinsed in clean water and was then air dried and packed for sterilization.

3.7 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

During the fourth stage of labor, close observation of the mother and baby were made for about six hours following the expulsion of the placenta, membranes and the subsequent arrest of hemorrhage. During this period, mother and baby were assessed for every fifteen minutes for two hours, thirty minutes for an hour and one hourly for three hours which was recorded behind the partograph. This was done to detect any deviation from normal.

PREVENTION OF DISEASES

The baby was given two drops of chloramphenicol eye drops was instilled on baby's eyes as prophylaxes for eye infection. The cord was dressed with sterile cotton wool swabs and methylated spirit to prevent cord infection. Vitamin K1 was administered intramuscularly to prevent haemorrhagic disease of the new born. No bleeding was noticed. Hands were washed with soap under running water and dried with a clean dry towel afterwards.

EXAMINATION OF THE NEWBORN

Procedure was explained vividly to client, examination gloves were worn and baby was examined from head to toe to detect any deviation from normal. Baby was put on a flat surface. Baby was exposed and the general condition, respiration and skin color was noted and the baby was covered again to be examined from head to toe.

Head and neck: On examination of the head, the index and middle fingers was run through the suture line to check for any bulging fontanelles but no abnormality was detected. There was no laceration on the scalp and no caput succedaneum. The ears were examined for size, shape, patency, position, softness of the cartilage but no abnormality was detected. The eyes were in alignment with the ears and presence of an eyeball. There was no redness of the conjunctiva or

jaundice on the sclera. The nose was examined for shape, size, patency to rule out deviated septum and discharges but everything was normal. The mouth was examined for the presence of false teeth, cleft palate and tongue tie but there was none. Rooting, suckling and swallowing reflexes were present. There was no rigidity, congenital goitre and swelling of the neck.

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 color 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 were also noted and no abnormality was detected.

Chest examination: Respiratory movement was normal, nipples were in alignment, and breast had no mass.

Extremities: The upper extremities were inspected for equality, number of palmer creases, clubbed fingers, extra or loss digits. No abnormality was detected. Baby's ability to perform Moro and grasp reflexes were also checked. The lower extremities were inspected for equality, clubbed feet, extra or loss digits but none was present.

Abdominal examination: The abdomen was examined for shape and size, with no bleeding from the umbilical site and abnormalities such as omphalocele, gastroschisis were absent. Congenital hip dislocation was also checked using the Ortolani's test and there was no dislocation since a 'clunk' was not heard.

Back examination: The back of the baby was examined for abnormalities like spinal bifida, meningocele, but none was detected.

Genital examination: The vulva was well formed, urethra and anal orifices were patent as it passed urine and meconium respectively.

Measurement: Measurements of the baby were done; Head circumference 34 centimeters, Length of the baby was 48 centimeters. Baby's weight was 3.6 kilograms. Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to her. Baby's vital signs and weight were checked and recorded as follows;

Temperature - 36.0 degree Celsius

Apex heart beat - 130 beats per minute

Respiration - 44 cycles per minute

Weight - 3.6kilograms.

3.8 MANAGEMENT OF THE MOTHER

Client was reassured and encouraged to have enough rest and sleep. The mother's initial vital signs were checked and recorded as follows;

Temperature - 36.4 degree Celsius

Pulse - 90 beats per minute

Respiration - 20 cycles per minute

Blood pressure - 120/70 milliliters of mercury

The fundus was rubbed to facilitate contraction. Blood clots were expelled and blood loss was 150 milliliters, and the symphysio fundal height was 17 centimeters. Client was transferred to the lying-in-ward and baby put to breast. The total blood loss after the fourth stage was 100 milliliters. At the end of the fourth stage, the amount of urine passed was 100 milliliters. Lochia

was red in color (rubra), small in quantity and had no foul smell. Client was educated on frequent micturition and changing of perineal pads when soaked, how to fix baby to breast, the importance of exclusive breastfeeding for the first six months and feeding on demand was stressed on as well. Client's mother and husband were allowed to see her and she was served with warm porridge and bread to restore energy. General condition of client was good and all labor notes were recorded on the partograph sheet.

SUMMARY OF LABOUR

Client had a spontaneous vaginal delivery to a live female baby on 20th November, 2022 at 7:40am with birth weight 3.6kg with APGAR score 8/10 and 9/10. Placenta and membranes were completely delivered at 7:45am by controlled cord traction. Estimated blood loss was 150mls. Condition of mother and baby was satisfactory and they were made comfortable in bed.

3.9 CONDITION OF BABY AT BIRTH

General examination of the baby was done and no abnormalities detected. The baby had a pink skin color, umbilical cord was not bleeding. The baby was classified as normal and routine care given.

Baby passed urine and meconium within some few minutes after birth. The baby's vital signs were as follows;

Temperature - 36.0 degree Celsius

Apex heart beat - 130 beats per minute

Respiration - 44 cycles per minutes

APGAR score for first minute - 8/10

APGAR score for fifth minute - 9/10

Sex	-	Female
Weight	-	3.6kilogram
Length of the baby	-	48centimeters
Head circumference	-	34 circumference
Abnormalities	-	Nil
Condition of baby	-	Very good.

3.10 CONDITION OF MOTHER AFTER BIRTH

Client was made comfortable in bed and was helped to fix baby to breast. Vital signs were checked and the following examinations were done and recorded as follows;

Blood pressure	-	120/70 milliliters of mercury
Temperature	-	36.0 degree Celsius
Pulse	-	90 beats per minute
Respiration	-	20 cycles per minute
Fundus	-	17 centimeters
Blood loss	-	150 milliliters (small)
Bladder	-	100 milliliters

Condition of mother after delivery was good.

DURATION OF LABOUR

Duration of first stage	-	6hours
Duration of second stage	-	10 minutes
Duration of third stage	-	5minutes
Total duration of labor	-	6 hours 15minutes

3.11 CARE PLAN DURING LABOUR

Problems Identified During Labor

1. (20/11/22) - Client complained of lower abdominal pains

2. (20/11/22) - Client complained of nausea and vomiting

3. (20/11/22) - Client was anxious

4. (20/11/22) - Risk for electrolyte imbalance

5. (20/11/22) - Risk for infection

Short Term Objectives

1. Client will cope within lower abdominal pains till delivery.

2. Client will be relieved of nausea and vomiting within two hours.

3. Client anxiety will resolve within one hour.

4. Client will maintain a normal fluid and electrolyte balance within 48 hours.

5. Client will show no sign of infection within 48 hours.

Long term objectives

Madam Evelyn will go through labor and puerperium successfully without any complication.

TABLE 2. LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
20/11/22 at 1:00am	Alteration in comfort (Lower abdominal) pains related to uterine contractions in labor	Client will cope with labor pains throughout labor as evidenced by; 1.Client verbalizing she is coping with the pains 2. Midwife observing a relaxed facial expression of the client.	1. Reassure client that the lower abdominal pains will stop after labor. 2. Explain the process of labor to client. 3. Encourage client to practice deep breathing exercise. 4. Encourage client to empty her bladder frequently. 5. Engage client in a conversation as a form of divisional therapy. 6. Encourage ambulation.	1. Client was reassured that the lower abdominal pains will stop after labor. 2. The process of first and second stage of labor was explained to the client. 3. Client was encouraged to practice deep breathing exercise. 4. Client was encouraged to empty her bladder frequently. 5. Client was engaged in a conversation. 6. Client was encouraged to walk around her bed.	20/11/22 at 7:30am	Goal fully met.	JOK

LABOUR CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
20/11/22 at 2:00am	Risk for electrolyte imbalance Nausea and vomiting related to the physiology of labor	Client's nausea and vomiting will reduce within two hours during labor as evidenced by; 1. Client reporting that she no longer feels nauseated. 2.Midwife visualizing that client has stopped vomiting.	1. Reassure client to allay fear and anxiety. 2. Explain the physiology associated with nausea and vomiting. 3. Hydrate client to prevent dehydration by giving IV fluids. 4. Encourage client to reduce the intake of oily and spicy food. 5. Move away all nauseating objects from client.	1. Client was reassured to allay fear and anxiety. 2. The physiology of nausea and vomiting was explained to her understanding. 3. Client was given oral fluids to replace fluid loss. 4. Client was encouraged on the need to reduce the intake of oily and spicy foods. 5. Nauseating objects was moved away from client.	20/11/22 at 4:30am	Goal fully met.	JOK

LABOUR CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
12/11/22 at 2:30am	Anxiety related to unknown outcome of labor.	Client will be relieved of anxiety 1hour after delivery as evidenced by client delivering a healthy baby without any complication	1.Reassure client that she is in compliant and will delivery successfully. 2. Establish and maintain good interpersonal relationship with client. 3. Explain every procedure before and after implementation. 4. Communicate all findings to client. 5. Encourage client to ask questions and answer them tactfully. 6. Introduce client to other staffs who will attend to her	1.Client was reassured and will have successful delivery 2.Good interpersonal relationship was established. 3. Every procedure was explained to client. 4. Findings were communicated to client. 5. Client was encouraged to ask questions and answers were given tactfully. 6. Client was introduced to other staffs.	12/11/22 at 3:30am	Goal fully met .	JOK

LABOUR CARE PLAN CONTIBUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
20/11/22 at 2:00am	Risk for fluid and electrolyte balance (less than the body requirement) related to inadequate fluid intake.	Client will go through labor successfully without any sign of dehydration as evidenced by 1.The midwife Observing that client has normal skin turgor with moist and pink mucus membranes and 2.Client verbalizing that she is able to take sips at least 2 cups of water served	1. Reassure client that she will be well hydrated with a normal skin turgor. 2. Perform oral hygiene. 3. Monitor and record vital signs. 4. Assess skin turgor and mucous membranes for signs of dehydration. 5. Assess color and amount of urine output and record. 6. Encourage client to take in sips of water	1. Client was reassured that she will be hydrated and have a normal skin turgor during labor and puerperium. 2. Oral hygiene was performed. 3. Vital signs were monitored and recorded. 4. Skin turgor of client and mucous membranes were assessed for dehydration. 5. Color of urine and the amount produced were assessed and recorded. 6. Sips of water was taken by client.	20/11/22 at 2:30am	Goal was fully met	JOK

LABOUR CARE PLAN CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
20/11/22 at 3:00am	Risk of infection related to mishandling of perineal pad.	Client will be able to prevent infection within 48 hours after labor and throughout her stay on admission as evidenced by; The midwife visualizing that she shows no symptoms of infections and recording normal body temperature.	1. Reassure client that she will be free from infections. 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. 4. Educate client not to reapply perineal pad when it falls. 5. Explain to the client the need for proper handling of pad.	1. Client was reassured that she will be free from infections. 2. She was encouraged to wash her hands before and after touching perineal pad. 3. Client was educated to change perineal pad when soaked to prevent infections. 4. She was educated not to use perineal pad when it falls. 5. The need for proper handling of pad was explained to client.	22/11/22 at 9:20am	Goal successfully met	JOK

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter deals with the care given to the mother and the baby after delivery, baby's first bath, subsequent care of the baby, first day post-delivery care, post-delivery home visits, preparation towards discharge, post-natal review, care plan drawn for the management of the problems encountered during this period.

4.1 DAY OF DELIVERY

Madam Kafiska Anudia and her baby were observed closely for one hour before they were transferred into a warm and comfortable bed in the lying-in with baby still on skin to skin with mother. All observations and examinations done were recorded in the fourth stage notes. Both mother and baby were kept warm. She was encouraged to put the baby to the breast to promote bonding between them and also stimulate uterine contractions to aid involution of the uterus. She was also advised to empty her bladder frequently to help in fast involution of the uterus.

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 advised to change the baby's soiled napkins and diapers frequently to prevent nappy rash and to make the baby comfortable. She was encouraged to wash her hands under running water with soap after visiting the lavatory, changing her perineal 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 perineal pad frequently.

Her vital signs were checked and recorded as follows;

Temperature - 36.3ºC

Pulse rate - 90bpm

Respiratory rate - 22cpm

Blood pressure - 120/70mmHg

The symphysio-fundal height was measured to be 17 centimeters. Lochia was also inspected and it was red (rubra) in color and small in amount with no bad odor. 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. Client complained of lower abdominal pains. Physiology of after pain was explained to her, tablet Paracetamol was served with good effect. Warm compresses were applied to the lower abdomen. Client was advised 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 pad. Client 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. Client's mother was advised to assist her in the care of the baby and also the household chores. She was then informed of possible discharge the following day.

4.2 SUBSEQUENT CARE OF THE BABY

Six hours after the delivery, the baby was bathed with warm water. Head to toe examination was done. Cord was dressed with chlorhexidine using aseptic technique and the cord was checked for bleeding and no abnormalities were detected. The baby passed meconium and urine which indicated that urethra and anus were patent. The baby was dressed nicely, wrapped in a warm dry cot sheet to maintain body temperature, and was placed beside her mother to breastfeed. The mother was advised not to place any other items on the cord with the exception of chlorhexidine that will be given to her. She was encouraged to practice exclusive breastfeeding.

BABY BATH AND CORD DRESSING

REQUIREMENTS

1. Soap
2. Sponge
3. Cream / powder
4. Sterile cotton in a gallipot or wrapped
5. Chlorhexidine
6. Basin
7. Towels: 1 big towel and 3 small ones
8. Cot sheets 2
9. Apron
10. Gloves

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

12. Mackintosh

13. Two jugs containing hot and cold water each

14. Two receptacles for used water and dirty linen

15. A receiver for used swab

PROCEDURE

The procedure was explained to mother and a tray was set. All windows and door were closed, fans switched off and lights switched on to make the room warm. A plastic apron was worn and hands were washed with soap and water and dried with a clean towel. The water was mixed and the temperature was tested using the back of the palm. Examination gloves were worn and baby was placed on a flat surface. She was undressed and wrapped in a big towel. The eyes were cleaned with cotton wool swabs soaked in clean water from inner canthus outwards. Her face was cleaned with damp face towel and dried. The nape of baby's neck was supported with one hand. Her ears were then plugged using two fingers of the hand and the head was washed with soapy sponge. With the body resting on the elbow and still supporting the nape, the baby was placed at the edge of the bowl to rinse the soap off the head and dried.

She was exposed; arms and front of trunk were washed paying attention to skin folds. The baby's back was turned with one hand supporting the chest and washed back down to feet paying attention to the skin folds. She was immersed in a bath of warm water with the head above the water and rinsed thoroughly. The baby was placed on a flat surface covered with clean sheet. The baby was dried by using a clean small towel paying attention to the skin folds. Baby oil was applied on the skin and baby was dressed leaving the umbilical cord exposed for

dressing and the hair combed neatly. Gloved hands were dipped into 0.5 percent chlorine solution 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

Head circumference - 34centimeters

Length - 48 centimeters

Weight	-	3.6kilograms
Apex beat	-	142 beats per minute
Temperature	-	36.2 degree Celsius
Respiration	-	44 cycles per minute

Baby's condition was good.

At 8:00am mother and baby were seen to find out how they were faring, they were in good condition. They were both examined and their vitals were checked since they were not yet discharged;

Temperature	-	36.4 degree Celsius
Pulse	-	89 beats per minute
Respiration	-	22 cycles per minute
Blood pressure	-	119/70 millimeters of mercury.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-delivery was 20th November, 2022. Mother and baby were seen in the lying-in ward at 2:00pm to find out how they were faring. Greetings were exchanged and She was asked about how she and the baby were doing and she said they were both doing well, except that she had lower abdominal pains (after pains) while breastfeeding 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 1mg Paracetamol to reduce the pain. She was encouraged to have enough sleep when the baby was asleep. She was urged to change baby diapers when wet. She had already emptied her bladder and taken her bath. A puerperal assessment was then

made. The conjunctiva was inspected for sign of anemia but it was absent. Lactation was good when the breasts were assessed. The uterus had contracted very well and the symphysio fundal height measured 17cm. The perineal pad was inspected and the Lochia was red (rubra), with small flow and there was no offensive odor. She took her baby after she was served with Hausa porridge and a loaf of bread as breakfast.

Madam Kafiska's vital signs were checked and recorded as follows;

Temperature	-	36.1 degree Celsius
Pulse	-	78 beats per minute
Respiration	-	20 cycles per minute
Blood pressure	-	110/80 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, odor 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	-	36.4 degree Celsius.

Pulse - 132 beats per minute.

Respiration - 44 cycles per minute.

Weight - 3.6 kilograms.

The baby was given the first immunization Bacilli Culmette Guerine (BCG) 0.05millimeters vaccine intradermal 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 the back of the tongue was also given orally to protect the baby against polio myelitis. Vitamin K was 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. she 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;

- • Tablet Fersolate 200mg (1 daily) for 20 days

- • Tablet Multivitamin 200mg (1 daily) for 20 days
- • Folic acid 5mg (daily) for 20 days
- • Tablet metronidazole 400mg (3times daily) for 5 days
- • Amoxicillin capsule 500mg (3times daily) for 7 days

The dosage and time for taking the drugs were explained to her. Madam Kafiska 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 that day at 5:00pm and was escorted with her items into a car brought in by her husband. They were reminded of the visit to their house.

4.4 FIRST DAY POST NATAL HOME VISIT (2ND DAY POST DELIVERY)

On 21st November, 2022 a visit was made to Madam Kafiska's house at 8:30am and 5:00pm. On arrival, greetings were exchanged with a warm welcome. She said her condition was getting better and that there had been an improvement on the complaints. She added that the baby was doing well. The family was pleased. Explanation was given to Madam Kafiska that she and the baby were going to be examined from head to toe to detect any abnormality for early treatment. She was encouraged to empty her bladder if she has the urge. The conjunctiva was examined and there was no pallor. The breasts were firm and well lactating. The uterus was firm and symphysio fundal height measured 16cm. The perineum was inspected and was found to be cleaned; lochia was red (rubra) with small amount of flow.

Mother's vital signs were taken and recorded as;

Temperature	-	36.2 degree Celsius
Pulse	-	78beat per minute
Respiration	-	20cycle per minute

Blood pressure - 110/60 millimeters of mercury

Permission was sought to top and tail the baby and it was granted. As the baby was being wiped, it was also demonstrated to Client. The cord was also dressed with chlorhexidine gel. The cord was clean and showed no signs of infection. The baby had passed meconium and urine when the napkin was removed. Baby was examined from head to toe and no abnormality was found. Baby was not jaundiced or pale and was able to suckle well.

Baby's vital signs were taken and recorded as follows;

Temperature - 36.6 degree Celsius,

Heart rate - 136 beats per minute,

Respiration - 40 cycles per minute

Cord - clean

Baby's weight - 3.5 kilograms

At 5:00pm mother was also examined from head to toe and there were no abnormal changes. The fundal height measured 16cm. The perineum was inspected and was found to be cleaned; lochia was red (rubra) with moderate amount of flow.

Mothers' vital signs were taken and recorded as;

Temperature: 36.4 degree Celsius

Pulse: 78beat per minutes

Respiration: 21cycle per minutes

Blood pressure: 110/70 millimeters of mercury

Observation on Baby

Observation	**Evening**
Temperature	36.7 degree Celsius
Apex beat	130 beat per minutes
Respiration	42 cycle per minutes
Cord	Clean
Weight	3.4kg

Client was encouraged to breastfeed the baby on demand. A promise was made to visit them again the following day. Client and her family said goodbye.

4.5 SECOND DAY POST NATAL HOME VISIT (3RD DAY POST DELIVERY)

On the 22nd November, 2022 the second visit was made to Madam Kafiska's house at 8:00am and 5:30pm respectively and She said her condition had improved. Baby was also doing well. Permission was sought from client to inspect her perineal pad and perineal area was clean and the Lochia was red, not offensive and the flow was small. She emptied her bladder and the Head-to-toe examination was also done and everything was normal. The breast was firm and well lactating. Uterus was firm and symphysio fundal height measured 15cm.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 and weight were taken and recorded as follows;

OBSERVATION	MORNING	EVENING
Temperature	36.30C	36.40C
Pulse	80bpm	80bpm
Respiration	20cpm	20cpm
Blood pressure	100/60mmHg	100/60mmHg
Lochia	Rubra	Rubra
Fundal height	15cm	15cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

The baby was topped and tailed paying attention to the skin folds and general examination was carried out on the baby from head to toe and no abnormality was revealed. The cord was neatly dressed and it was dry with no sign of infection. The baby passed stools and urine according to client. Baby was assessed and recorded as follows;

BABY OBSERVATIONS	MORNING	EVENING
Temperature	37.2C	37.0C
Heart rate	140bpm	138bpm
Respiration	38cpm	40cpm
Skin Color	Pink	Pink

Cord	Clean and dry	Clean and dry
Suckling	Yes	Yes
Weight	3.3kg	3.3kg
Stool Color	Yellowish	Yellowish

Nothing abnormal was detected during the examination. Madam Kafiska 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 her 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 sitz bath on each visit. Family members were encouraged to help in activities so that mother could have adequate sleep. Permission was sought to leave and Madam Kafiska said she was very grateful and appreciated the care that was given to them.

4.6. THIRD POSTNATAL HOME VISITS (4TH DAY POST DELIVERY)

On the 23rd November, 2022, the third home visit was made to Madam Kafiska's house at 8:30am and 5:10pm. Mother and baby were doing well and Madam Kafiska's husband had left for work. Permission was sought to inspect Madam Kafiska's perineal pad and the lochia was serosa (pink) without offensive odor. 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 14cm. 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 odor. The baby also passed greenish yellow stools and urine. Mother and baby's vital signs were checked and recorded as follows;

MOTHER 4TH DAY (23/11/22)

OBSERVATIONS	MORNING	EVENING
Temperature	36.0	36.4
Pulse	69bpm	71bpm
Respiration	22cpm	20cpm
Lochia	Serosa	Serosa
Fundal Height	14cm	14cm
Condition of Uterus	Contracted	Contracted
Breast	Lactating	Lactating
Blood Pressure	110/70	110/70

Nothing abnormal was detected during the examination. Baby was topped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was neatly dressed and was dry without bad odor. The baby also passed stools and urine. Baby's vital signs and other observations were taken and recorded as follows;

BABY OBSERVATION	MORNING	EVENING
Temperature	37.0C	37.0C
Apex heart beat	136bpm	134bpm
Respiration	44cpm	40cpm
Skin color	Pink	Pink
Condition of cord	Clean and dry	Clean and dry

Suckling	Yes	Yes
Weight	3.3kg	3.3kg
Stool color	Dark yellow	Dark yellow

Permission was sought to leave and client said she was very grateful. Client complained of pain in her breasts which was as a result of fullness. She was educated to continue breastfeeding the baby, and to apply cold compress on them to reduce the pain. She was advised to ensure that one breast was empty before the other and appreciated the care that was given to them very much.

4.7 FOURTH DAY POST NATAL HOME VISIT (5TH DAY POST DELIVERY)

Madam Kafiska and her baby were visited again on 24th November, 2022 at 8:00am to continue with the postnatal care. She and her baby were physically examined and nothing abnormal was detected.

Lochia was pink on inspection. Head to toe examination was done and everything was normal. Symphysio-fundal height measured 13cm. 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. Client 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. The baby passed dark yellow stools and urine. Mother and baby's vital signs were checked and recorded as follows;

MOTHER

OBSERVATION	**VALUES**
Temperature	36.20C
Pulse	80bpm

Respiration	20cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	13cm
Condition of the uterus	Contracted
Breast	Lactating but engorged

Baby had been topped and tailed by client's mother in my presence so the general examination was carried out. No abnormality was found. The cord was neatly dressed and no abnormality was detected. The baby passed stools and urine.

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

BABY

OBSERVATION	**VALUES**
Temperature	36.7C
Heart rate	130bpm
Respiration	48cpm
Skin Color	Pink
Cord	Dry
Weight	3.3kg
Suckling	Yes
Stool Color	Dark yellow

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

4.8 FIFTH POSTNATAL HOME VISIT (6TH DAY POST DELIVERY)

The fifth postnatal home visit was on 25th November, 2022 at 9:30am. Greetings were exchanged with client and her family after which a seat was offered. Mother and baby were both in a healthy condition and when it was inquired, client said the fullness of the breast had subsided except that the baby still cried a lot and she had not emptied the bowel for three days. She was reassured and advised to feed the baby well and change napkins before she slept and also to take enough fluid and food rich in fiber to aid in peristalsis. Inspection of the lochia was done and the color was serosa (pink) without any odor indicating that personal hygiene was maintained. She was advised to change pad frequently to prevent infection and she was educated on family planning. After the head to toe examination, no abnormality was detected. Assessment was done and recorded as follows;

MOTHER

OBSERVATION	**VALUES**
Temperature	36.0C
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	12 cm
Condition of the uterus	Contracted
Breast	Lactating but engorged

Baby was given a warm bath paying attention to the skin folds, because the cord was off. 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 recorded as follows

BABY

OBSERVATION	**VALUES**
Temperature	37.2C
Heart rate	136bpm
Respiration	38cpm
Skin Color	Pink
Cord	Dry
Weight	3.4kg
Suckling	Yes
Stool Color	Yellow

Madam Kafiska 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 POSTNATAL HOME VISIT (7TH DAY POST DELIVERY)

The sixth postnatal home visit was made on 26th November, 2022 at 8:20 am. 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 11cm. Inspection of the lochia was done and the color was serosa (pink) with odor 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 was assessed and recorded as follows:

MOTHER

OBSERVATIONS	**VALUES**
Temperature	36.20C
Pulse	76bpm
Respiration	21cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	11 cm
Condition of uterus	Contracted
Breast	Lactating

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 assessments were recorded as follows

BABY

OBSERVATIONS	**VALUES**
Temperature	37.0C
Apex heart beat	134bpm
Respiration	40 cpm
Skin color	Pink
Cord	Dry
Weight	3.5kg

Suckling	Yes
Stool color	Light brown

Madam Kafiska 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 POSTNATAL HOMEVISIT (8TH DAY POST DELIVERY)

The seventh postnatal home visit was made on 27th November, 2022, Client and baby were visited in the morning at 9:00am. Mother and baby were doing very well 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 color was serosa (pink), flow was scanty without any bad odor. Symphysio fundal height measured 10cm. After the head to toe examination, no abnormality was detected. Mother and baby's vital signs were as follows;

BABY

OBSERVATIONS	**VALUES**
Temperature	36.6C
Apex heart beat	134bpm
Respiration	40cpm
Skin color	Pink
Cord	No
Weight	3.6kg
Suckling	Yes
Stool color	Light brown

MOTHER

OBSERVATIONS	VALUES
Temperature	**36.20C**
Pulse	**76bpm**
Respiration	**21cpm**
Blood pressure	**110/60mmHg**
Lochia	**Serosa**
Fundal height	**10cm**
Condition of uterus	**Contracted**
Breast	**Lactating but engorged**

Client 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.

Client 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. She was again reminded on the circumcision of her baby on the first postnatal visit to the clinic. They were told that day was the last visit.

4.11 FIRST POST NATAL VISIT TO THE CLINIC

Client and her baby reported at the Clinic on 28th November, 2022. She was accompanied by her sister. Mother and baby looked healthy and cheerful. They were welcomed to the postnatal unit 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 Kafiska and

hands were washed and dried. The fontanelles and sutures were examined for any bulging fontanelles 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 3.6kg and her vital signs checked and recorded were as follows;

Temperature - 37.0°C

Pulse rate - 134bpm

Respiratory rate - 40cpm

Symphysio-Fundal height was 9cm. All findings were communicated to mother and recorded. Mother claimed the baby has good bowel movement and breastfeeds well.

Midstream urine was taken to check for protein and sugar in urine but they were both negative. Haemoglobin level was 11.8g/dl when the Hb was checked.

Client was also examined and before that, she was asked to empty her bladder after the procedure has been explained to her. She was assisted onto the examination couch and privacy was provided. Hands were washed and dried.

On inspection, client's hair was clean and nicely plaited. Madam Kafiska's conjunctiva and sclera were 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. On abdominal palpation, the uterus was no longer palpable. The lochia was serosa. She was helped out of the examination couch after the examination. Findings were communicated to her and documented.

Client was advised to maintain good personal and environmental hygiene in the care of herself and the baby. client 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. The baby was taken to the birth registry where she was registered and certificate was given to the mother. Client was reminded of the six weeks postnatal visits to the clinic.

Gratitude and thanks were expressed to Client and the entire family for their support and co-operation throughout the writing of the care study. She was finally handed over to the midwife in-charge to continue with the care.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in-charge, Madam Kafiska′s six weeks postnatal visit was on 30th December, 2021. At 8:00am, she came to the facility with her sister. Head to toe examination was done on her and nothing abnormal was present.

Her vital signs, including the weight were checked and recorded as follows;

Temperature	-	36.5ºC
Pulse	-	80bpm
Respiration	-	20cpm
Blood pressure	-	110/60mmHg
Weight	-	73kg

Madam Kafiska’s urine was checked for protein and sugar and it was negative for both, and the hemoglobin was12.0g/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 - 36.3degree Celsius

Respiration - 41cpm

Weight - 3.8kg

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.

4.13 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

Madam Kafiska complained of:

- On 23/11/22, After-pain.
- On 23/11/22, Altered sleep pattern
- On 25/11/22, Engorged breast
- On 25/11/22, Rash on baby's skin

• On 26/11/22, Backache.

SHORT TERM OBJECTIVES

- • Madam Kafiska After pain will resolve within 48 hours
- • Client will have at least 6hours at night within 72 hours
- • Client's breast engorgement will be relieved within 72 hours
- • Client will have a normal bowel movement once daily within 24 hours
- • Client's backache will be relieved within 72 hours.

LONG TERM OBJECTIVE

Mother and baby will pass through puerperium without any complications.

TABLE 3. CARE PLAN DURING PUERPERIUM

DATE/ TIME	**NURSING DIAGNOSIS**	**OBJECTIVES/ OUTCOME CRITERIA**	**NURSING ORDERS**	**NURSING INTERVENTIONS**	**DATE/ TIME**	**EVALUATION**	**SIGN**
23/11/22 at 8:00am	Impaired body comfort (After pain) related to involution of the uterus	Client's pain will be relieved within 24hours as evidenced by: 1.Client verbalizing that after pain has reduced. 2.Midwife visualizing that client is calm and relaxed in bed off after pain.	Reassured client that pains will be stop. 2. Explain the cause of after 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 that the pains will stop shortly after a while. 2. The cause of after pain was explained to client. 3. Client assumed any comfortable position of her choice. 4. Client emptied her bladder frequently. 5. Client was served with analgesics Paracetamol 1g.	24/11/22 at 8:00am	Goal fully met.	J.O.K

CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
23/11/22 at 8:00am	Altered sleep pattern related to baby's crying and feeding at night.	Client will have at least for 6 hours sleep at night each day within 72 hours as evidenced by: client verbalizing that she now sleeps for at least 6 hours at night and 2 hours during day time	1. Reassure the client. 2. Advise 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. 5. Advise client to rest during the day.	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. 5. Client rested during day time.	26/11/22 at 8:00am	Goal was fully met.	J.O.K

CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
25/11/22 at 10:15am	Engorgement of the breast related to inadequate emptying of the breast.	Client's breast engorgement will be relieved within 72hours; As evidenced by; 1. client verbalizing that she feels comfortable in her breast 2. midwife visualizing that the fullness is reduced.	1. Reassure client. 2. Teach her how to fix baby correctly to the breast. 3. Teach client how to correctly position herself when breastfeeding. 4. Encourage client to empty one breast before the other. 5. Encourage client to continue breastfeeding the baby exclusively.	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 one breast before the other. 5. Client was encouraged to continue breastfeeding the baby exclusively.	28/11/22 at 10:15am	Goal fully met.	J.O.K

CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
25/11/22 at 8:00am	Impaired skin integrity (Skin rashes) on baby related to heat (atmosphere temperature).	Baby skin rashes will resolve within 72 hours as evidenced by 1. Mother verbalizing that rash has resolved. 2. Midwife observing that baby is having no skin rashes	1. Reassure mother. 2. Explain the physiology of rash to the mother. 3. Educate mother to dress baby with cotton cloths. 4. Educate client not to scratch the rashes.	1. Client was reassured. 2. Physiology of rash was explained to mother. 3. Mother dressed baby with cotton cloths. 4. Client was educated not to scratch the rashes as it would cause more pain and infection.	28/11/22 at 8:00am	Goal fully met.	JOK

CARE PLAN DURING PUERPERIUM CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
26/11/22 at 4:00pm	Altered body comfort (Backache) related to physiological changes during pregnancy	Client will be relieved of backache within 24 hours as evidenced by Client verbalizing, she is relieved of backache	1.Reassure client. 2. Explain the physiology of backache to the client. 3. Encourage client to sleep on a firm mattress. 4.Give body massage. 5. Educate client against lifting of heavy loads.	1. Client was reassured. 2. Physiology of backache was explained to client. 3. Client was encouraged to sleep on a firm mattress. 4. Body massage was given. 5. Client was educated on the need to avoid lifting of heavy loads.	27/11/22 at 4:00pm	Goal fully met.	J.O.K

TERMINATION OF CARE

This is the period in which the relationship between the midwife and client comes to an end. The family centered maternity care on Kafiska Anudia started on 7th November, 2022 and finally came to an end on 28th November, 2022 at ARMS Hospital in the Bono East Region during her antenatal visit to the clinic. She was rendered a holistic and individualistic care from the time she was met, which was during her third trimester of her pregnancy through to labor and puerperium. She had spontaneous vaginal delivery to a live Female child on 20th November,2022. She encountered some minor problems during pregnancy, labor and puerperium, with laboratory investigations, examinations and nursing care plan. Her identified problems during pregnancy, labor and puerperium were solved without any complication arising.

During her first postnatal visit to the clinic, she and her baby were looking healthy. She was handed over to the midwife in charge for continuity of care.

This study has helped me put into practice what I have learnt in the class room and at the ward. It has also helped me to gain more experience in the antenatal care and care during labor and puerperium.

SUMMARY AND CONCLUSION

Madam Kafiska aged 24 years Gravida 2 Para 1 alive and a native of Aworowa in the Bono East Region. She was met when she was 37 weeks pregnant on the 7th of November, 2022 during eight weeks practical experience at the ARMS Hospital, Techiman. She was chosen as a client to help her go through pregnancy, labor and puerperium successfully without any complications after she consented. 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 Kafiska's labor and delivery were managed carefully without any complications. She delivered spontaneously an alive female infant with birth weight 3.6 kg on the 20th November, 2022 at 7:40am who cried immediately after birth. Madam Kafiska's puerperium was successful, mother and baby were visited at home and finally handed over to the Midwife In-charge for further management on 28th November, 2022.

The Family Centered Maternity Care has afforded me the opportunity to identify the various needs of the expectant woman during pregnancy, labor 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 the 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 I

TABLE 4: MOTHER'S ANTENATAL CARE

DATE	**WEIGHT** (KG)	**BLOOD PRESSUE**	**URINE FOR PROTEIN/ SUGAR**	**GESTATIONAL AGE IN WEEKS**	**FUNDAL HEIGHT** (CM)	**PRESENTATION**	**DESCENT OF FETAL HEAD**	**FETAL HEART RATE(FH)**	**TREATMENT GIVEN**	**COMPLAIN**	**SIGN**
14/05/22	72kg	107/50mmHg	Negative/ Negative	12weeks	NP	-	-	-	Routine drugs	No complain	J.E
26/06/22	70kg	113/62mmHg	Negative/ Negative	16weeks	16cm	-	-	134bpm	Routine drugs	No complain	J. E
14/07/22	75kg	122/62mmHg	Negative/ Negative	21weeks	21cm	-	-	130	Routine drugs	No complain	J.E
12/08/22	74kg	116/56mmhg	Negative/ Negative	25weeks	26cm	Cephalic	-	146bpm	Routine drugs	Feels well	J.E
13/09/22	82kg	123/64	Negative/ Negative	29weeks	29cm	Cephalic	-	137bpm	Routine drugs 1G of Paracetamol x7	No complain	J.E

MOTHER'S ANTENATAL CARE CONTINUED

DATE	**WEIGHT (KG)**	**BLOOD PRESSUR**	**URINE FOR PROTEIN/ SUGAR**	**GESTATIONAL AGE IN WEEKS**	**FUNDAL HEIGHT** (CM)	**PRESENTATION**	**DESCENT OF FETAL HEAD**	**FETAL HEART RATE** (FH)	**TREATMENT GIVEN**	**COMPLAIN**	**SIGN**
11/10/22	74kg	114/70mmHg	Negative/ Negative	33weeks	32cm	Cephalic	5/5th	135bpm	Routine drugs	Feels well	J.E
25/10/22	76kg	125/70mmHg	Negative/ Negative	35weeks	35cm	Cephalic	5/5th	139bpm	Routine drugs	Feels well	J. E
07/11/22	78kg	123/63mmHg	Negative/ Negative	37weeks	36cm	Cephalic	5/5th	140bpm	Routine drugs 1G of paracetamol tids x 7	Lower abdominal pains	J.O.K
14/11/22	77kg	109/58mmHg	Negative/ Negative	38weeks	36	Cephalic	5/5th	144bpm	Routine drugs	No complain	J.O.K
18/11/22	78kg	119/60mmhg	Negative/ Negative	39weeks	37	Cephalic	5/5th	142bpm	Routine drugs	Lower abdominal pain/waist pain	J.O.K

TABLE 5. ITN GIVEN – (14/05/22)

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

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1 Yes TD 2 and TD3 NO TD4		TD5 NO	
CURRENT TD 3rd dose				Date: 14/07/22		Date
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 14/06/22	Gestation age In weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 14/07/2022	Gestation age In weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)12/08/22	Gestational age in weeks
16weeks				21weeks		25weeks
4th dose 3 tabs (Direct observed therapy)11/10/22	Gestation age in weeks 33weeks		5th dose 3 tabs (Direct Observed Therapy)15/11/22		Gestation age in weeks 38 weeks	

APPENDIX II

TABLE 6. ANTENATAL COMPLETED DIAGNOSTIC INVESTIGATIONS

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
10 / 06 / 2022	1. Blood	Haemoglobin level	12g/dl-16g/dl	11.0g/dl	Normal
		Sickling status	Negative	Negative	Normal
		Grouping and	A, B, AB, and O	B	Normal
	2. Urine	Rhesus factor	Positive and	Negative	Normal
		HIV status	Negative	Negative	Normal
		VDRL	None reactive	Non-defect	Normal
		Hepatitis status	None reactive	Negative	Normal
		G6PD status	Negative	Non-defect	Normal
		Sugar	None reactive	Negative	Normal
		Protein	Negative	Negative	Normal
			Negative		

TABLE 7. COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
12/08/22	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
13/09/22	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
11/10/22	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
25/10/22	1. Urine 2. Blood	Sugar Protein Haemoglobin Level	Negative Negative 12g/dl-16g/dl	Negative Negative 11.9g/dl	Normal Normal Normal
07/11/222	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUED

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
14/11/22	1. Urine 2. Blood	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
Haemoglobin	12g/dl-16g/dl		12.0g/dl	Normal	
18/11/22	1. Urine 2. Blood	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
Haemoglobin	12g/dl-16g/dl		12.2g/dl	Normal	

APPENDIX III

TABLE 8. PHARMACOLOGICAL DRUGS FOR MOTHER

NAME OF DRUG	**CLASSIFICATION**	**DOSAGE**	**ROUTE**	**USE AND ACTION**	**ACTUAL EFFECT**	**SIDE EFFECT**	**SIDE EFFECT EXPERIENCED**
Tablet multivitamin	Vitamin preparation	200milligram once daily	Orally	Increased appetite and Helps in the formation of red blood cells.	Increased appetite	Gastrointestinal disturbances	No side effect observed.
Tablet folic acid	Haematinics	5 milligrams once daily	Orally	Proper formation and functioning of red blood cell.	Haemoglobin level increase	Nausea and vomiting	No side effect observed
Tablet Ferrous sulphate	Iron supplement	200 milligrams once daily	Orally	Helps in the formation of haemoglobin and red blood cells	Increased haemoglobin level	Gastrointestinal disturbances. Dark stools.	Dark stools

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'D

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet Metronidazole	Antibiotic	400 mg 3 times daily	Orally	Fights against bacterial infection	Fights against bacterial infection	Stomach pain, dizziness, dry mouth, cough, sore tongue	No side effect observed
Tablet Paracetamol	Analgesic and anti-pyretic	1 gram 3 times daily	Orally	Relieve pain and Reduce body temperature	Pain relieved	Prolonged use may cause liver damage.	No side effect observed.
Capsule Amoxicillin	Antibiotic	500mg 3 times daily	Orally	Fights against bacterial infection	Bacterial infection prevented	Nausea, stomach pain, diarrhoea, vomiting	No side effect observed

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'D

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet Sulphadoxinepyrimethamine	Antimalarial and Malaria prophylaxis	3 tablets start 1st dose at 16 weeks or after quickening and 4 other doses at 4 weeks interval until delivery.	Orally	Treatment and prevention of malaria	Malaria prevented	Itching Nausea Dizziness Headache	No side effect observed.
Tetanus Injection	Anti-tetanus	0.5 milligrams	Subcutaneously	Provides immunity against Tetanus disease.	Tetanus prevented	Fever Chills Urticarial rash	Pain at the site.
Injection oxytocin	Oxytocic drug	10 units	Intramuscularly	Stimulates uterine contractions	Uterine contractions stimulated	Nausea and Vomiting	No side effects observed

PHARMACOLOGICAL DRUGS FOR BABY

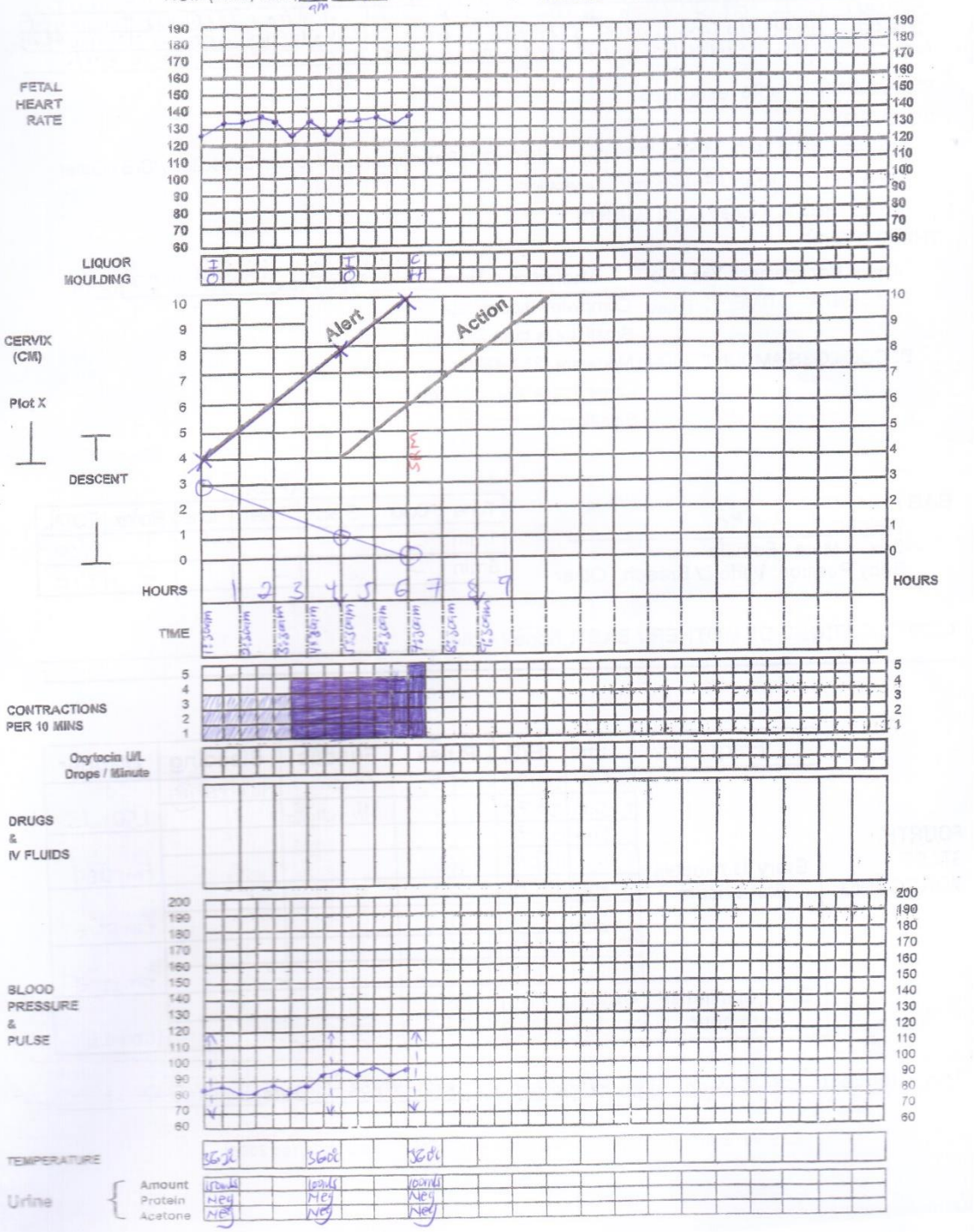
NAME OF DRUG	**CLASSIFICATION**	**DOSAGE**	**ROUTE**	**USE AND ACTION**	**ACTUAL EFFECT**	**SIDE EFFECT**	**SIDE EFFECT EXPERIENCED**
Injection vitamin k	Coagulant (Group K Vitamin)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting	No bleeding	Risk of haemolysis in people with G6PD deficiency	No side effects observed.
Chloramphenicol eye drop	Antibiotic	2 drops	Instillation	To prevent eye infection	Eye infection was prevented	Transient stinging	No side effect observed.
Oral polio vaccine	Antigen vaccine	2 drops	Orally	Production of antibodies to prevent poliomyelitis.	Poliomyelitis was prevented.	Diarrhoea and Fever.	Observed

PHARMACOLOGICAL DRUGS FOR BABY CONTINUED

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Capsule vitamin A	Group A vitamin supplement	200,000 unit for 2 days	Orally	Growth, development and proper sight	Normal vision and healthy skin	Vomiting	No side effect observed.
Injection Bacillus Calmette Guerin (BCG)	Antigen vaccine	0.05 milligrams	Intradermal injection	Production of antibodies against tuberculosis	Still under observation	Blister formation and fever	Blister observed

WHO Modified Partograph

Registration No. 007685/19 Name (Last, First) KAFISKA ANUSHA Age 24 years
Date 20/11/22 Parity/Gravida 1 / 2 LMP 30/03/22 EDD 19/11/22 Gestation (wks) 39 weeks
ROM (Time, Date) 2:30 pm 20/11/22 Labour Durable (Hrs) 6 hrs 15 min Facility/Clinic Name ARMS HOSPITAL



LABOR NOTES

On 2th November, 2022 client G2P14 with EDD 24/11/22 Estimated Gestational age 39 weeks into the facility complaining of labour pains vital signs was checked, blood sample taken to lab, PVE was done and dilorated at 4cm. At 7:30am client complain of labour pains and was encouraged to bear down, client gave birth to an alive female baby at 7:40am with APGAR score of 8/10, 9/10 Birth weight 3.6kg length 48cm, head circumference 34cm, baby shown to mother and third stage actively managed. baby and mother made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 20/11/22 TIME: 7:40am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 7:41am Type/Dose 10units of oxytocin

PLACENTA: TIME: 7:45am (Complete) / Incomplete

BLOOD LOSS AMOUNT: 150mls (Small (Less than 250 cc) / Moderate (250-499 cc) / Large (more than 500 cc) / Significant for mother

BABY

Weight: 3.6kg

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	8:00am	120/70	90	17cm	No bleeding	
	8:15am	120/70	90	well contracted	11	150mls
	8:30am	120/70	92	11	11	
	8:45am	119/70	88	11	11	Emptied
	9:00am	119/70	89	11	11	
	9:15am	119/70	86	11	11	Emptied
	9:30am	116/70	92	11	11	
	9:45am	120/70	90	11	11	Emptied
Every 30 minutes For 1 hour	10:15am	120/70	86	11	11	
	10:45am	120/70	89	11	11	100mls

Birth Attendant OBENG JESSICA KISSIWAA ASSISTED BY GRACE YEBOAH Date 20/11/22

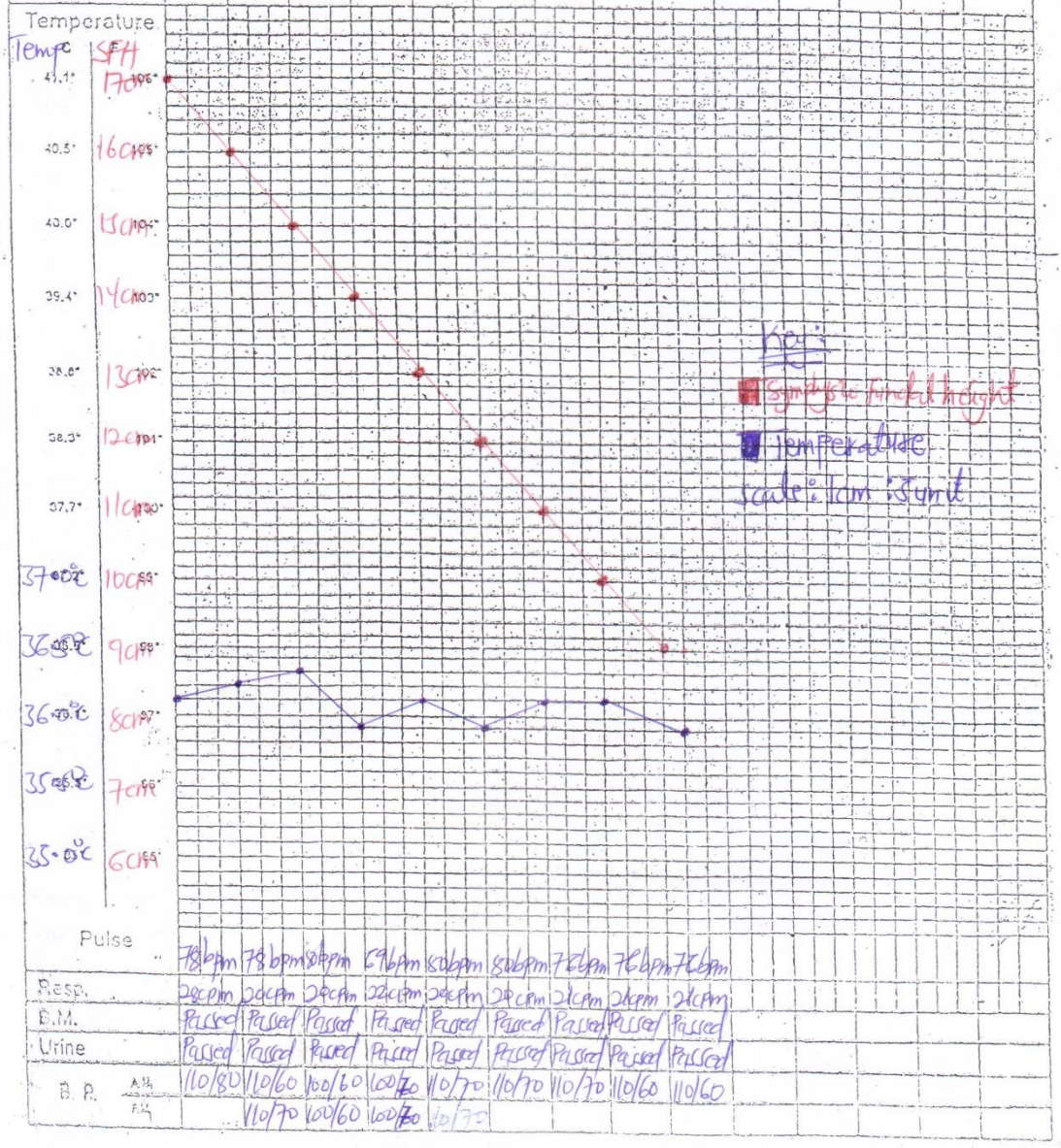
MATERNITY CHART

NAME: KAFISKA ANUDIA

AGE: 24years WARD: LABOUR-IN

IP NO.: 009686/19 BED NO.: 2

Date	20/11/22	21/11/22	22/11/22	23/11/22	24/11/22	25/11/22	26/11/22	27/11/22	28/11/22
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour AM	7:00	8:30	8:00	8:00	8:00	9:30	8:20	9:00	8:00
Hour PM	-	5:00	5:30	5:10					
Temperature Temp °C / °F									
Pulse	78bpm	78bpm	84bpm	69bpm	80bpm	80bpm	72bpm	76bpm	72bpm
Resp.	20cpm	20cpm	20cpm	20cpm	20cpm	20cpm	20cpm	20cpm	20cpm
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM	110/80	110/60	100/60	100/70	110/70	110/70	110/70	110/60	110/60
B. P. PM		110/70	100/60	100/80	110/70				



NEW BORN EXAMINATION FORM

Name: BABY KAFISKA AHUDIA Date of Assessment: 20/11/22 Time: 9:00am
Date of Birth: 20/11/22 Time of Birth: 7:40am Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 1hr:20mins
Astational Age ☐ ☐ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: ☐ 3.6 kg ☐ Length: 48 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.4° °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): OBENG KISSIWAA JESSICA

1. Respiration
Rate 44
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 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 testes
☐ Abnormal meatus
☐ Hernia
☐ Other:

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

24. Anus
☑ Patent
☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral
Diagnoses (if known) TERM BABY

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

NEW BORN EXAMINATION FORM

Name: BABY KAFISKA ANUBIA Date of Assessment: 20/11/22 Time: 4:00pm
Date of Birth: 20/11/22 Time of Birth: _____ Sex: ☐ M ☑ F Age at time of Assessment (days/hrs) 8hrs.
Astational Age ☐ ☐ Mode of Delivery: ☐ Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: ☐ 3.6 kg ☐ Length 48 cm Head Circumference: 34 cm
Temperature at time of Assessment: 36.4 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): OBEN'G KUSSIWAA JESSICA

1. Respiration
Rate 44
☐ Rate < 30 b/m *
☐ Rate < 60 b/m *
☑ 30-60 b/m
☐ Retractions *
☐ Grunting *
☐ Stridor *

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

3. Tone
☑ Normal
☐ Floppy *
☐ Increased *

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

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

6. Cry
☑ Normal
☐ Shrill *
☐ Absent *

7. Suck
☑ Good
☐ Weak
☐ Absent

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

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

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

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

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

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

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

16. Clavicle
☑ Normal
☐ Swelling/Fracture

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

18. Heart rate
Rate: 132
☑ 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
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☐ Normal
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☑ BCG ☑ Polio Immunization
☑ Antibiotics in mother
☐ Antenatal corticosteroids

*May indicate severe disease that requires urgent referral
Diagnoses (if known) TERM BABY

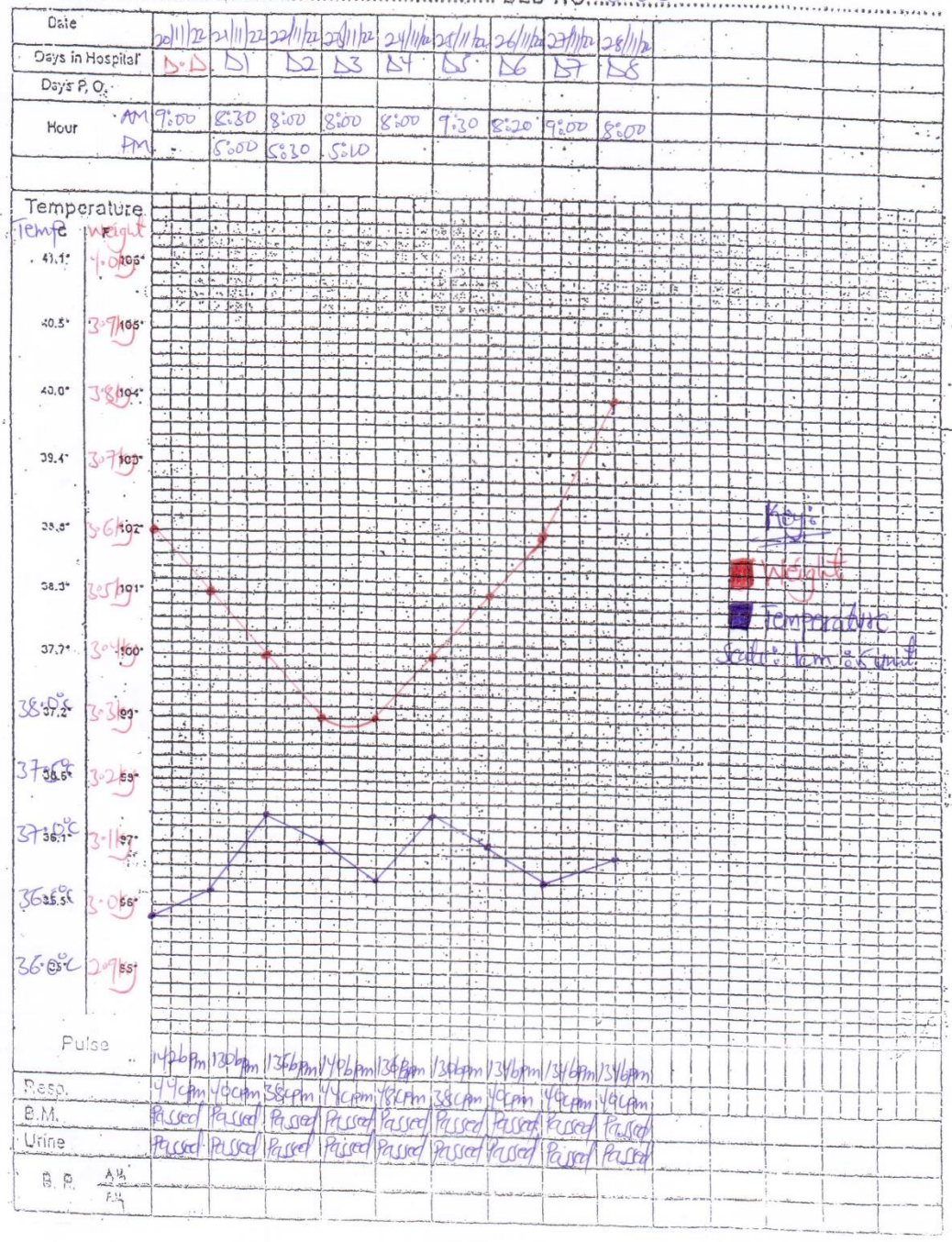
Classification: (Overall assessment) [✓] Normal [ ] Baby with a Problem [ ] Danger Sign/ <1500g/ severe Jaundice
Plan: [ ] Routine Care[ ]Problem. Continue supportive in-patient care [ ] Urgent Referral / Advanced Care[✓] Discharge

TEMPERATURE CHART

NAME: BABY KAFISKA AHUDIA

AGE: NEWBORN WARD: LYING-IN

IP NO.: BED NO.: Cot 6



NEW BORN CHART

Name: BABY KAFISKA ANUDIA ..... No: ..... Birth Weight: 3.6kg .....

Sex: FEMALE ..... Mother's No: 009686/19 ..... Length: 48cm .....

Nature of Delivery: SPONTANEOUS VAGINAL DELIVERY ..... Diagnosis: TERM BABY .....

Date of Birth: 20TH NOVEMBER, 2022 ..... Time: 7:40pm ..... Date of Discharge: 20TH NOVEMBER, 2022 .....

Date	20/11/22		21/11/22		22/11/22		23/11/22		24/11/22		25/11/22		26/11/22		27/11/22		28/11/22					
No. of Days	D.O		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.6kg		3.5kg		3.4kg		3.3kg		3.3kg		3.4kg		3.5kg		3.6kg		3.8kg					
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
	36.4°C		36.6°C	36.7°C	37.2°C	37.0°C	37.0°C	37.0°C	36.7°C		37.2°C		37.0°C		36.6°C		37.0°C					
Stools	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Urine	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed		Passed		Passed		Passed					
Remarks	Head Neck Trunk Genitalia Lower Limbs > No Abnormalities Detected																					

SIGNATORIES

THE STUDENT MIDWIFE

NAME: OBENG JESSICA KISSIWAA

SIGNATURE:.....

DATE:7th July, 2023.....

THE MIDWIFE IN-CHARGE (ARMS HOSPITAL, TECHIMAN)

NAME: GRACE YEBOAH

SIGNATURE:..... (for)

DATE:14/07/2023.....

THE SUPERVISOR

NAME: MARTHA KYEREMAA

SIGNATURE:.....

DATE:14/07/2023.....

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE:.....

DATE:14/07/2023.....