HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON MADAM HANNAH BOAA

BY

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TABLE OF CONTENTS

TABLE OF CONTENTS ii
PREFACE iv
ACKNOWLEDGEMENT v
INTRODUCTION vi
LITERATURE REVIEW vii
WHY I CHOSE MY CLIENT xviii
CHAPTER ONE 1
CLIENT/FAMILY ASSESSMENT 1
1.0 INTRODUCTION 1
1.1 PERSONAL AND SOCIAL HISTORY 1
1.2 FAMILY HISTORY 1
1.3 MEDICAL HISTORY 2
1.4 SURGICAL HISTORY 2
1.5 MENSTRAL HISTORY 2
1.6 HABIT OF DAILY LIVING 2
1.7 PAST OBSTETRIC HISTORY 3
1.8 PRESENT OBSTETRIC HISTORY 4
CHAPTER TWO 6
ANTENATAL CARE 6
2.0 INTRODUCTION 6
2.1 FIRST CONTACT WITH CLIENT 6
2.2 FIRST ANTENATAL HOME VISIT 11
2.3 SUBSEQUENT ANTENATAL HOME VISIT 13
2.4 SUBSEQUENT VISIT TO THE CLINIC 14
2.5 NURSING CARE PLAN DURING ANTENATAL 15
CHAPTER THREE 22
LABOUR 22
3.0 INTRODUCTION 22
3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR 22
3.2 MANAGEMENT OF SECOND STAGE OF LABOUR 27
3.3 IMMEDIATE CARE OF THE BABY 28
3.4 ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR 29
3.5 EXAMINATION OF THE PLACENTA AND MEMBRANES 30
3.6 MANAGEMENT OF FOURTH STAGE OF LABOUR 32

3.7 SUMMARY OF LABOUR 33
3.8 NURSING CARE PLAN DURING LABOUR 35
SHORT TERM OBJECTIVES 35
LONG TERM OBJECTIVES 35
CHAPTER FOUR 41
PUERPERIUM 41
4.0 INTRODUCTION 41
4.1 DAY OF DELIVERY 41
4.2 SUBSEQUENT CARE OF THE BABY 42
4.3 FIRST DAY POST DELIVERY AND DISCHARGE 45
4.4 FIRST POSTNATAL HOME VISIT 48
4.5 SECOND POSTNATAL HOME VISIT 49
4.6 THIRD POST NATAL HOME VISIT 51
4.7 FOURTH POSTNATAL HOME VISIT 54
4.8 FIFTH POSTNATAL HOME VISITS 56
4.9 SIXTH POSTNATAL HOME VISIT 58
4.10 SEVENTH POSTNATAL HOME VISITS 60
4.11 FIRST POSTNATAL VISIT TO THE CLINIC 62
4.12 SECOND POST NATAL VISIT TO THE CLINIC 64
4.13 CARE PLAN DURING PUERPERIUM 67
BIBLIOGRAPHY 84
APPENDIX I : ANTENATAL RECORD BOOK 85
APPENDIX II : COMPLETE DIAGNOSTIC INVESTIGATION 88
APPENDIX III: PHARMACOLOGY OF DRUG(MOTHER) 90
APPENDIX IV : PHARMACOLOGICAL DRUGS USED (BABY) 91
SIGNATORIES 93

PREFACE

Client/family centered maternity care study is the systematic way of administering midwifery care to a pregnant woman and her family throughout pregnancy, labour and puerperium.

The family centered maternity care is mainly based on total nursing care in which the physical, psychological, spiritual, social and rehabilitative aspect of the client is considered. It includes the expectant mother, her family and the community in preparing towards the impending arrival of the new family member.

The client/family centered maternity care study also help the student midwife to use new trends in midwifery like the partograph which is recommended and tested by World Health Organization (WHO). The active management of third stage of labour was also introduced to limit the occurrences of postpartum hemorrhage. The care study offers the student midwife the opportunity to put the knowledge and skills acquired during training into practice. It also enables her to detect problem and need of the mother and her family. Also the family centered maternity care study helps to reduce maternal and neonatal morbidity and mortality. The client and family centered maternity care study is compiled into a document in partial fulfillment for the award of registered midwifery certificate by the Nursing and Midwifery Council of Ghana.

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INTRODUCTION

The client and family centered maternity care study refers to all the midwifery care rendered to the expectant mother and her family throughout pregnancy, labour and puerperium. It entails every aspect of the woman's social, physical, spiritual and psychological wellbeing.

The care is considered within the framework of the family and the community with the aim of preparing the pregnant woman to face labour, puerperium and to initiate lactation and subsequent care of the baby.

This client/family centered maternity care study is about Madam Hannah Boaa, a 24-year old woman gravida 2 para 1A during her pregnancy, labour and puerperium period. This study of care is in four chapters;

The chapter one centers on client's particulars such as personal, social, medical, surgical, family, menstrual, obstetric, past and present histories.

Chapter two focuses on the antenatal care rendered to Madam Hannah Boaa throughout her pregnancy.

Chapter three is concerned about management of Madam Hannah Boaa during labour.

Chapter four gives detailed account on the management of client during puerperium.

In order to identify the client's problems and manage them accordingly, a nursing care plan is drawn at the end of each chapter followed by summary, conclusion, bibliography, and various records during pregnancy, labour and puerperium as well as the pharmacology of drugs that were administered.

LITERATURE REVIEW

PREGNANCY

Myles (2014) pregnancy is confirmed when many physiological changes take place in the body and return to its pre-pregnant state during puerperium due to the effect of certain hormones namely oestrogen and progesterone. These hormones are responsible for the major changes that take place during pregnancy. Even though these hormones have their own effects by causing the minor disorders that occur during pregnancy, they are one way or the other an advantage for the mother and the growing fetus since the fetus depends solely on the mother for survival when in utero. There are varieties of care that are rendered to the expectant mothers and their entire families include history taking, physical examination (head to toe examination and abdominal examination i.e. inspection, palpation and auscultation), laboratory investigation (urine, blood and stool), administration of routine drugs (folic acid, ferrous sulphate and multivitamins), and tetanus toxoid, education on minor disorders, danger signs of pregnancy, diet and rest and sleep, exercise, personal hygiene and environment hygiene, birth preparedness and complication readiness. The anatomical and physiological change in the uterus plays an essential role in pregnancy by protecting and supporting the fetus, placenta and amniotic fluid. At the time of labour it is able to contract regularly and forcibly to expel the fetus due to its unique properties of contractility and elasticity.

Marie Elizabeth (2013) defines pregnancy as when the woman's egg and a man's sperm cell unit to form zygote. The duration of pregnancy has been calculated by the clinicians in terms of 10 lunar months or 9 months and 7 days or 280 days or 40 weeks, calculated from the first day of the last menstrual period. This is called menstrual or gestational age. It is divided into 3 trimesters, a period of three months in each trimester. The first trimester begins from the fertilization of the ovum to 12 weeks of gestation. The second trimester begins from the 13th week to the 24th week of pregnancy. The third trimester starts from the 25th week to

the 40th week. General check-up is done at interval of 4 weeks up to 28 weeks; at interval of two weeks up to 36 weeks and thereafter weekly till the expected date of delivery. Ideally this should be more flexible depending on the need, and the convenience of the patient.

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

Henderson (2009) states that, pregnancy may be suspected by the woman base on her knowledge of her menstrual cycle, sexual activity and the signs of pregnancy. Women may confirm their pregnancy using home pregnancy test. Confirmation of pregnancy may also be sought from the midwife or doctor. This is established by a detail history and relevant clinical examination based on the signs and symptoms of pregnancy. The signs and symptoms of pregnancy are; amenorrhea, breast changes, nausea, and vomiting, increase frequency of micturition, enlargement of the uterus, skin changes and quickening. These signs will become obvious to the woman in sequential stages.

King (2014), pregnancy is a time of profound anatomic and physiologic change in a woman`s body. In addition to the reproduction organs all maternal physiologic system make adaptations needed to support the developing fetus and at the same time, maintain maternal homeostasis. Pregnancy last approximately two hundred and sixty-six days (266 days) or thirty- eight weeks (38 weeks) from ovulation. The prenatal period is divided into trimesters, first trimester is considered to be week(s) 1 to 12 (12weeks) because organogenesis is

completed at the end of twelve weeks and the risk of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28weeks because prior to the introduction of modern neonatal intensive care technique 28 weeks was limit of viability. The third trimester extends from weeks 29 to 40. The term ‘post-date’ or ‘post term’ is typically used to describe a pregnancy beyond forty weeks (40).

Konar (2013) stated that, during pregnancy, there is progressive anatomical physiological and biochemical change not only confined to genital organs but also to all systems of the body. This is principally a phenomenon of maternal adaption to the increasing demand of the growing fetus. Unless understood, this physiological adaptation to normal pregnancy can be misinterpreted as pathological. There is marked congestion with hypertrophy of the muscle and elastic tissues of the wall. In late pregnancy, the bladder mucosa becomes oedematous due to venous and lymphatic obstruction especially in primigravida following early engagement. Increased frequency of micturition is noticed at 6-8 weeks of pregnancy which subsides after 12 weeks. It may be due to resetting of osmoregulation causing increased water intake and polyuria. In late pregnancy, frequency of micturition once more reappears due to pressure on the bladder as the presenting part descends down the pelvis. Stress incontinence may be observed in late pregnancy due to urethral sphincter weakness. The gums become congested and spongy and may bleed to touch.

Muscle tone and motility of the entire gastrointestinal tract are diminished due to high progesterone level. Cardiac sphincter is relaxed and regurgitation of acid gastric content into oesophagus may produce chemical esophagitis and heart burn. There is diminished gastric secretion and delay emptying time of stomach. Risk of peptic ulcer disease is reduced. A tonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

Fraser and Cooper (2008) pregnancy is the fusion of the woman's egg and a man sperm cell unite to form a zygote. All changes in the mother's body during pregnancy are due to the effects of specific hormones. These changes enable her to nurture the fetus, prepare her body for labour and develop her breast and lay down stores of fats to provide calories for production of breast milk during puerperium. It states that, the woman's psychological state is also affected by hormonal changes. The gestational period is divided into three trimesters. The first trimester is from the time of conception to the 12th week. The second trimester is from the 13th week to the 24th week whilst the third trimester is from is from the 25th week to the 38th. During pregnancy, antenatal care is given to the woman throughout the period and should commence from the time pregnancy is diagnosed and continue until the safe delivery of the baby. This is why it is so important that the midwife has knowledge and understanding of the common disorders of pregnancy which include, constipation, fatigue, lower abdominal pain, waist pain, leg cramp, backache insomnia, increase vaginal discharge among others in order to advise the woman on strategies that will help her cope with the condition and minimize the effects she experiences.

LABOUR

Myles (2014) states that labour purely in physical sense may be described as the process by which the fetus, placenta and membranes are expelled through the birth canal. Labour has four stages. Stage one comprises of latent phase and may last 6 to 8 hours in primigravida. This begins when the cervix is 4cm dilated and in the presence of rhythmic contractions, progressively dilates to 10cm or full dilatation. Second stage of labour is the expulsion of the foetus. It begins when the cervix is fully dilated and the woman has the urge to expel the baby. There is stretching of the clitoris, gaping of the anus and bulging of the perineum. Labour completes when baby is born. In multigravida women, it last 15-30 minutes. Third stage begins after the expulsion of foetus and ends with the expulsion of the placenta and membranes (afterbirth). The fourth stage is a period of careful observation of the mother made to assess excessive bleeding and the firmness of the contracting uterus immediately after the third stage of labour and it last for six hours after delivery of the placenta.

Fraser and Cooper (2008) Labour is described as the process by which the products of conception are expelled through the birth canal. Labour was classified under four stages. The first, second, third and fourth stage. The first stage of labour begins with the dilatation of the cervix up to ten centimeters (10cm) dilation or full dilation of the cervix. This is a result of the regular rhythmic and painful uterine contractions. The second stage of labour also starts when the cervix is fully dilated and it continuous till the expulsion of the fetus. The third stage of labour is the complete expulsion of the placenta and its membranes and the control of bleeding. The fourth stage also is the six hourly close observations of the mother and the baby after the third stage. It involves the checking of the vital signs of both the mother and the baby every 15 minutes within the first hour after the delivery of the placenta and membranes. It also deals with the establishment of lactation and detection of abnormalities and any complications in both mother and baby. During this stage, the mother is also given

health education on personal hygiene, care of the cord, frequent change of perineal pad, frequent ambulation to prevent postpartum haemorrhage and exclusive breastfeeding.

Fraser, D.M. & Cooper, M.A (2009). *Myles Textbook for Midwives* (15th ed.), London: Churchill Livingstone Ltd. defined labour as the process by which the foetus, placenta and its membranes are expelled through the birth canal. It described four stages of labour:

First stage: The latent phase is prior to active first stage of labour and may last six to eight hours in first time mothers when the cervix dilates from 0 centimeters to 3 – 4 centimeters.

The active first stage is the time when the cervix undergoes more rapid dilatation. This begins when the cervix is 3 – 4 centimeters dilated and in the presence of rhythmic contractions is complete when the cervix is fully dilated (10 centimeters).

The transitional (transient phase) is the stage of labour when the cervix is from around 8 centimeters dilated until it is fully dilated and it is within the active phase.

Second stage: The second stage is the expulsion of the foetus. It begins when the cervix is fully dilated and ends when the foetus is delivered. The woman usually feels the urge to expel the foetus during this stage of labour.

Third stage: The third stage is that of separation and expulsion of placenta and membranes and control of hemorrhage. It last from birth of baby until the placenta and membranes have been completely expelled.

Fourth stage: It starts from complete expulsion of the placenta and membranes up to the first six hours following delivery and monitoring of mother and baby.

Tiran (2008) Labour is defined as the process by which product of conception are expelled from the uterus through the birth canal. Labour normally occurs spontaneously at term that is between 38 and 42 weeks of pregnancy. The fetus should present with vertex and once

started, the contractions should increase in strength and frequency without interruption and artificial stimulation until foetus, membranes and placenta are expelled by the maternal effort through the vagina. Partograph is the graphical recording of labour progress obtained by assessment of visual patterns of cervical dilatation and descent of the presenting part in conjunction with records of maternal and foetal wellbeing.

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

Konar (2011) states that, labor is a series of event that takes place in the genital organ in an effort to expel the viable products of conception out of the womb through the vagina into the outer world. Onset of labor is very much unpredictable to foretell precisely the exact date of onset of labor. It not only varies from case but even in different pregnancies of the same individual. Conventionally events of labor are divided into four stages: First stage starts from the onset of true labor pains and ends with full dilatation of the cervix. average duration is twelve hours (12) in primigravida and six hours (6) in multipara. Second stage starts from the full dilatation of the cervix (not from the rupture of the membranes) and ends with expulsion of the fetus from the birth canal. It has got two (2) phases thus the propulsive phase starts from full dilatation up to the descent of the presenting part to the pelvic floor and the

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

PUERPERIUM

Marie Elizabeth (2013) puerperium is the period following childbirth during which the body tissues, especially the pelvic organs reversed back approximately to the pre-pregnant state both anatomically and physiologically. The period is divided into; Immediate –within 24 hours, Early- up to 7 days, Remote –up to 6 weeks, immediately following delivery, the uterus becomes firmer and retracted with alternating hardening and softening. At the end of 6 weeks, its measurement is almost similar to that of the non-pregnant state and it weighs 60 grams. The lower uterine segment becomes thin, flabby and collapsed structure. The cervix contracts slowly; the external os admits a fingers for the few days but by the end of the first week, narrows down to admit the tip of a finger only. The external os never revert back to the nulliparous state. Puerperium is the number of muscle fibers is not decreased but there is substantial reduction in the myometrium cell size. The arteries are constricted by contraction of its wall and thickening of the intima followed by thrombosis. New blood cells grow in the thrombi. Soon after birth it takes a long time (4 to 8) for the vagina to involute. The vaginal discharge for the first fortnight during puerperium is the lochia. The lochia originates from the uterine body, cervix and vagina. Depending upon the variation of the color of the discharge it is named as Lochia rubra (red) 14 days. Lochia serosa (yellowish or pink or pale brownish) 5- 9 days. Lochia alba (pale white) 10 -15 days. The average amount of discharge, for the first 5-6 days is estimated to be 250 ml. With all definitions and changes. it can be deduced that puerperium is the period from birth to 6 weeks of delivery.

National Safe Motherhood Service Protocol (2008) postnatal period is the period that starts from the end of delivery of the placenta and membranes and control of hemorrhage to six weeks after delivery. The purpose of postnatal care is to maintain the physical and psychological wellbeing of the mother and child. Postnatal care includes education of the mother on the care of her baby, detection and treatment or referral of any abnormalities for further management. The essential components of postnatal care are therefore:

Comprehensive screening to detect complications in both mother and baby, Treatment of complications in mother and baby, Assessment and support for infant feeding, Malaria and anemia prevention. Some common discomforts of postpartum period in mothers listed are after pains, perineal pain, bowel and urinary changes, stretch marks, fatigue, sleeplessness, backache, headache, hemorrhoids and mood changes in the two weeks. Those associated with the newborn are caput succedaneum, tongue tie, rashes and vomiting after feeds. The major causes of death in this period are infections, hypertensive complications, hemorrhage and thromboembolism of which predisposing factors include: Conditions or complications during the antenatal period, Complications of labor, related to duration of labor and mode of delivery Henderson (2009), the postnatal period or puerperium is traditionally defined as the time from immediately after the end of labour until the reproductive organs have returned as nearly as possible to their pre gravid condition, a period estimated to be around 6-8 weeks. Changes in the urinary tract include a marked diuresis after delivery which lasts for 2-3 days. This is due to the reduction in blood volume occurring in the immediate postnatal period. The dilatation of the urinary tract, which occurs in pregnancy due to increased vascular volume, resolves and the renal organs gradually return to their pre gravid state. The falling progesterone levels affect the alimentary tract. The smooth muscle tone gradually improves throughout the body, and symptoms of heartburn the woman may have experienced should resolve. Constipation may however remain a common problem during the postnatal period.

Myles (16th edition) states that, following the birth of the baby and expulsion of the placenta, the mother enters a period of physical and psychological recuperation. Puerperium starts immediately after delivery of the placenta and membranes and continues for six weeks. The general expectation is that by six weeks after the birth, a woman's body will have recovered sufficiently from the effects of pregnancy and the process of parturition. The difference between exercise and healthy activity verses rest, relaxation and sleep. Exploring each person's level of activity will encourage advice in relation to appropriate exercise and by

association, nutritional intake and rest or relaxation and sleep. Undertaking regular pelvic floor exercise is of benefit to the woman's long term health.

Fraser and Cooper, (2008) Puerperium starts immediately after the delivery of the placenta and its membranes and continuous for six weeks. It is within this period that all systems of the woman's body recover from the effects of pregnancy and return to their non-pregnant state. Lactation is well established and baby accepted into the family. During this period also, there is the drainage of lochia (the discharges from the uterus). It is normally red in colour during the first 3-4 days described as lochia rubra, from 5-9 days, it is pink in colour and is called lochia serosa; and from next 2-3 weeks it is paler, creamy-brown in colour and this is called lochia alba. It has been traditional to associate after pains with multiparity and breastfeeding. However, women experience after pains regardless of whether they have had previous pregnancies and when they are not breastfeeding. Management of after pains is by an appropriate analgesic.

Konar (2013) puerperium is the period following childbirth during which the body tissues, specifically the pelvic organs reverse back approximately to the pre-pregnant state both anatomically and physiologically. This begins as soon as the placenta is expelled and last for approximately six weeks when the uterus becomes regressed to the non-pregnant size called involution, the period is arbitrarily divided into(a) immediate-within 24 hours;(b) early-up to 7 days and remote up to 7days. In its anatomical consideration, the uterus immediately following delivery becomes firm and retract with alternate hardening and softening. The uterus measures about 20×12×7.5 centimeters (length, breadth and thickness) and weighs about 1000grams. At the end of six weeks, its measurement is almost similar to that of the non-pregnant state and weighs about sixty (60) grams. The physiological consideration of involution is most marked in the body of the uterus where the changes occur in the muscles, blood vessels and endometrium.

WHY I CHOSE MY CLIENT

Madam Hannah Boaa was chosen as a client for the family centered on the 15th of November, 2021 at Agyei-Mensah Memorial Maternity Home at Ahafo Region of Ghana. Madam Hannah Boaa came to the facility with the complaints of lower abdominal pains. Her antenatal book was checked and realized that she was a regular attendant and her previous delivery was normal. Client was reassured and then to help her manage the abdominal pains. Client was 37weeks pregnant. Again, she fell within the required criteria used in maternity care study. She was informed that she would be taken as a client for the study and she would be monitored during pregnancy, labour and puerperium. She gladly agreed to the care that will be rendered to her.

CHAPTER ONE

CLIENT/FAMILY ASSESSMENT

1.0 INTRODUCTION

This chapter gives information about client and it includes personal and social, family, medical, surgical, menstrual, past obstetric, present obstetric history, and client life style and hobbies.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Hannah Boaa, gravida two [2] para one [1] alive, is a 24 - year old woman who resides at Gyedim, a suburb of Goaso in the Ahafo Region. She is fair in complexion, and weighs 69kg.

She is a JHS graduate. She added that she could not continue her education due to financial problems faced by her parents and decided to engage in trading.

Madam Hannah Boaa is married to Mr. Richard Appiah a 32-year old man who is a driver. Mr. Richard is a J.H.S graduate. Madam Hannah and her husband speak Asante Twi, and English.

They have one son, namely, Akwasi Appiah who is 4 years old. Madam Hannah Boaa and her family are Christians and worship at Lighthouse Chapel International. Her next of kin is her husband, Mr. Richard Appiah.

1.2 FAMILY HISTORY

The parents of Madam Hannah Boaa are Mr. Karikari and Mrs. Ruth Oduro. She has six other siblings; four females and two males, who are all alive.

Madam Hannah Boaa said her family has no medical condition like hypertension, sickle cell disease, heart disease, epilepsy, mental illness and others in the family.

She also added that most of the deaths in her family are natural, meaning they grow very old before death take them away. She has multiple pregnancies running through her family.

1.3 MEDICAL HISTORY

Madam Hannah Boaa has no known history of hypertension, heart disease, sickle cell disease, diabetes, jaundice, respiratory disease, epilepsy or mental illness. Client has been admitted to the hospital before. Client has no known allergy for food or drugs.

1.4 SURGICAL HISTORY

Madam Hannah Boaa said she has never undergone any surgical operation since childhood and had not involved in any road accident which could affect her spine.

1.5 MENSTRAL HISTORY

According to Madam Hannah Boaa, she had her menarche at the age of 14 and she has 28 days' menstrual cycle with regular and moderate flow of blood for 5-6 days without dysmenorrhea.

She added that she uses sanitary pad and changes it when it is soaked and bath twice daily. She also said her last menstrual period was 19th March, 2021 and her expected date of delivery was calculated to be 27th November, 2021.

1.6 HABIT OF DAILY LIVING

Client wakes up at 7am to do her household chores. After the house chores, she prepares breakfast for the family. She often empties her bowel twice daily, bath twice daily and rest during her leisure time. Her favorite food is rice and stew. Supper is usually prepared before 6:00pm.

On Sundays she doesn't go to work, she prepares breakfast for the family, bath her son and prepare for church. She goes to bed at 8:00pm.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Hannah Boaa has two pregnancies with one birth (G2P1) with her first pregnancy in 2016 and the second pregnancy in 2021 without any complications such ask vaginal bleeding, hyperemesis and ante- and post- partum hemorrhage. Client attended her antenatal care (ANC) regularly during her previous pregnancy at the Agyei-Mensah Memomorial Maternity Home and received four doses of sulphadoxime pyrimetamine and Tatanus diphtheria injection. Client was asked about any family planning method that she had practiced but client explained that she had not practiced it before. Her child is in good health.

LABOUR

According to client, with her previous child she delivered per vaginum spontaneously with perineum intact and could not remember the duration of labour. Baby cried immediately after delivery and placenta and membranes were completely delivered with minimum blood loss. According to Madam Hannah Boaa she was discharged twenty-four hours after delivery at the ward. Average weight was3.0kg

PUERPERIUM

Client explained that her baby was very healthy throughout the post- partum period with normal weights. Client breastfed baby for six months and started complementary feeds, such as porridge and water. However, the baby was breastfed up to two years before weaning her completely. The growth of the child was monitored at the child welfare clinic and he is healthy.

1.8 PRESENT OBSTETRIC HISTORY

Having glanced through her antenatal records book, client attended her first antenatal clinic visit on the 25/05/2021 at Agyei-Mensah Memorial Maternity Home when she was 13weeks of gestation.

Madam Hannah said her last menstrual period was 19/03/2021 and her expected date of delivery was calculated to be 27/11/2021.

Client had no complains during the first Antenatal visit. She weighed 69kg and her height was 155cm at booking.

Vital signs and laboratory investigations were conducted and recorded as follows;

Hemoglobin	8.5 gram per deciliter
Hepatitis B	Negative
Blood Group	B
Rhesus Factor	Positive
VDRL	None
HIV Status	Negative
G6PD	Nonreactive
Urine for protein and sugar	Negative
Sickling status	Negative

Vital signs and other observation were recorded as;

Temperature	36.6 degree Celsius
Blood pressure	100/60mmHg
Pulse	78 beats per minute
Respiration	18 circle per minute
Weight	69 kilograms
Height	155 centimeters
Symphysio fundal height	Early Pregnancy

Head to toe examination was done with no abnormality detected. She was 13 weeks, fundal height was early, fetal heart rate was not present, and there was no descent and no presenting part by then. She had no complications.

She had not taken her 3rd dose of Tetanus Toxoid [TT3] and had not taken any dose of Sulphadoxine pyrimethamine. She was counseled on malaria prevention, hygiene, good nutritious food, exercise, rest and sleep. She was given treated mosquito net. She was also given routine drugs as follows;

Tablet multivitamin 200mg Tid for 30 days

Tablet folic acid 1dly for 30 days

Caps Iron 111 Polymaltose 1dly x 30 days

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter gives information about the antenatal visits of the client and the care that was rendered to the client from the first encounter with the client and subsequent visits by the client to the clinic. It also talks about the number of visits made by the student midwife to the client's home till labour set in.

2.1 FIRST CONTACT WITH CLIENT

On Monday 15th November, 2021, Madam Hannah Boaa was encountered when she came to the clinic for her antenatal care. She came with the complain of lower abdominal pains, headache and since she was in her 37 weeks of gestation. An opportunity was taken to educate her about the physiological changes that occurs during pregnancy even though she had an experience. Explanation on the procedures to be carried out was done to seek her consent of which she accepted. Her weight and hemoglobin level was checked and recorded as 69kilograms and 8.5gram per deciliter respectively.

Her vital signs and other investigations were recorded as follows;

Temperature	-	36.6 degree Celsius
Pulse	-	78 beat per minute
Respiration	-	18 cycles per minute
Blood pressure	-	100/60 millimeter of mercury

After checking and recording of vital signs, head to toe examination was to be done so she was asked to empty her bladder and sample of her urine was taken and tested for sugar and protein which tested negative. She was helped to undress, gown and aided to assume a left

lateral position on the examination bed. Hands were washed and dried and all equipment needed for the examination was gathered.

GENERAL PHYSICAL EXAMINATION

A tray comprising of the following items;

1. A sterile gallipot with sterile cotton wool swabs with a lid
2. A receiver for used cotton wool swabs.
3. A tape measure
4. A fetal stethoscope
5. A watch with a second hand
6. A pen and client's folder

Head and neck examination

Client's hair was examined for cleanliness, scalp for lice, dandruff, ringworm, alopecia, skin infection and no abnormality was detected. Client was congratulated for keeping the hair clean and encouraged to keep it up. The face was inspected for edema, rashes and chloasma and nothing abnormal was detected. Her eyes were also inspected for pallor of the conjunctiva, yellowish or jaundice of the sclera but no abnormality was detected.

The ears were also inspected for discharges and alignment with the eyes and nothing abnormal was detected. The mouth was inspected for dryness, cracks and infections of the lips. She was asked an open-ended question which was used to detect any mouth odour. The gums and tongue for pallor, sores, and lesions and the teeth for decay but no abnormalities were detected. She was encouraged to brush her teeth two times daily and rinse her mouth after each meal.

The neck was palpated for enlarged thyroid gland, distended neck veins and enlarged lymph nodes and nothing abnormal was detected.

Breast examination

Both breasts were exposed to check for size, shape and condition of the skin. One breast was covered and was asked to put the hand to be examined under her head. The breast was palpated systematically in a circular manner using the inner aspect of the fingers and client was taught self- examination of the breast, nipples were squeezed gently for fluid (colostrum) for odour or blood and cleaned with cotton wool swab. On examination, both breasts were almost equal in size and no lymph nodes and lumps detected. Client was encouraged on the need to perform self-breast examination regularly as it helps in early detection of any abnormality. Client was encouraged to wear well- fitting braziers to support the breast and enhance comfort.

Extremities

The upper and lower extremities were checked for tingling sensations, tightness of fingers on making a fist with the hand, edema, palms and nail beds were checked for pallor, tenderness of calf muscles, varicose veins and capillary refill but there were no abnormalities and no extra digits.

Abdominal examination

Inspection: The abdomen was inspected and there was no scar as an indication of previous operation. There was however the presence of linea nigra. The shape and size of the uterus was globular and medium respectively and fetal movements were obvious.

Symphysio-fundal height: Palms were rubbed together to generate warmth in other to prevent stimulation contraction. The xiphisternum and upper boarder of the symphysis pubis

were located. The zero mark of the measuring tape was placed on the fundus and extended along the contour of the abdomen along the midline to the upper boarder of the symphysis pubis and it measured 37cm and her gestational age was 37 plus 4 days.

Fundal palpation: Upon facing the head end of the woman, palms were rubbed together to generate warmth in other to avoid inducing contraction. The palms were placed on either side of the fundus for fundal palpation. The fingers were curved around the fundus to determine what lies in the upper pole. A soft mass was felt there which indicated the buttocks. The fundus has grown to the level of the xiphisternum.

Lateral palpation: Still facing the woman, the palms were place on each side, with one hand stabilizing one side of the maternal uterus, the other hand was moved gently in a rotational manner where the fetal leg was palpated at the right side. This was repeated at the other side and the fetal back was felt with the left side. The position of the fetus therefore was occipito-anterior.

Pelvic palpation: Position was changed to the feet of the client as pelvic palpation was done. Madam Hannah was asked to bend her knees and also to breathe in and out slowly and the palms were placed just below the level of the umbilicus with the fingers directed towards the symphysis pubis and the thumb almost meeting. On palpation hard mass was felt indicating the head of the foetus.

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

Auscultation: The fetal stethoscope (fetoscope) was warmed by rubbing it on the palms. The fetoscope was placed at the area where the back was located to listen to the fetal heart rate 138bpm.

Vulva examination

Permission was sought to inspect her vulva and perineum and she agreed. She was thought how to assume a lithotomy position while she was helped to undress and was draped afterwards. Soap and water were used in washing hands and cleaned with a dry clean towel. A sterile glove was worn. Client was asked to assume lithotomy position and to expose the vulva. The vulva was inspected, the skin was smooth, clean and pubic hair was free of lice. The labia tissue was soft, there was no swelling, redness or tenderness, rashes, sore, scars, warts, edema, varicose veins and no discharges. Clitoris and perineum were inspected and no abnormalities were found. There was no sign of female genital mutilation. The vulva was moist with no offensive smell. Madam Hannah Boaa was congratulated for her co-operation. Glove was dipped in 0.5% chlorine solution, remove and discarded. Hands were washed with soap and water and dried with towel. Findings were communicated to her. Permission was then sought from Madam Hannah Boaa to come to her house the following day for a visit.

Health education was given on birth preparation and complication readiness plan and eating of nutritious diet. She was encouraged to report any abnormalities detected to the clinic very early and was reminded of the next visit to the health center.

Her medications were served as follows;

Tab folic acid 5mg 1dly x 14days

Tab ferrous sulphate 200mg 1dly x 14days.

Tab multivitamins 200mg 1dly x 30days

She was encouraged to take the drugs as prescribed and reminded again of the next visit to the health center. She was thanked for the cooperation and accompanied her to board a car.

2.2 FIRST ANTENATAL HOME VISIT

On Saturday, 20th November, 2021, a visit was made to Madam Hannah Boaa's house around 4:30pm. The aim of the visit was to observe her surrounding and inspect her items for labour and find out how she was coping with pregnancy.

Madam Hannah Boaa stays at Gyedim near the main station of Goaso. She lives in an uncompleted building with two entrances. There are eight bed rooms and roofed with aluminum sheet. She shares the same toilet and bathroom facility with the people in the house. There is no electricity available and their source of water is a well and pipe borne which is a walking distance away from their house. Since client do not have a kitchen, she cooks in an open space. She has a small dustbin which was well covered for keeping their rubbish and she empties whenever it is full. On arrival, her mother in-law was sitting outside while client was in the room. A seat was offered and client was called out. The purpose of the visit was asked as tradition demands and was stated accordingly. Permission was asked to enter into client's room to inspect her things for delivery. Client room was well ventilated with windows. Her room was neatly arranged and was congratulated on that. In order to know how prepared she was for labour, she was kindly asked to bring her bag containing the items for labour and it was encouraging because items like cot sheets, baby dresses, perineal pad, pampers and others were seen. Everything needed for labour were seen. She sleeps under insecticide treated net every day.

Client complained of finding it difficult to sleep (it is alteration in sleeping pattern related to frequency of micturition) and frequent micturition it is related to descent of the presenting part and was encouraged to cope with it throughout pregnancy). Client also complained of loss of appetite (altered nutritional pattern related to hormonal changes during pregnancy).

She was advised to take a warm bath before going to bed and educated on the need to practice good oral hygiene. Client was congratulated on how neat and clean she had kept the house and was educated on regular exercise and also reminded on the intake of nutritious diet. She was also educated to report to the clinic immediately when she experienced any of the true labour signs like the presence of show and painful rhythmic uterine action. Madam Hannah Boaa was thanked for her hospitality and permission was sought to leave.

PHYSICAL ENVIRONMENT

She resides at Gyedim a town at Goaso in the Ahafo Region. She lives in a cemented uncompleted building. Her bathhouse is located outside the house. Her source of water supply is by pipe borne which is near the house. Madam Hannah stores water in barrels which are neatly covered with a lid and she empties it whenever it's full at the community refuse dump. The compound is neat, no stagnant water or choked gutters. There is electricity but no water supply in the house. she fetches pipe borne water from the community which is about 5 minutes' walk from her house and stores it in a clean plastic container with a lid. She stays in the house with her partner and some family members. She has a good cordial relationship with her relatives as well as the people in her neighborhood. Client's layette was inspected and everything was intact. The items were neatly arranged in a medium-sized travelling bag and they included items such as; cot sheets, baby's clothing including socks and cap, perineal pads, toilet rolls, rubber (mackintosh) for delivery, cloths, and many more.

PSYCHOSOCIAL HISTORY

Madam Hannah and her Family has a cordial relationship with her neighbours. She is sociable and neither smokes nor takes in alcohol. Client attends the church every Sunday. She takes her daily prayers very seriously. Madam Hannah has respect for her fellow people and likes to crack jokes. Madam Hannah has a good relationship with her neighbours which clearly shows whenever she is visited in the house.

Client was educated on true labour signs such as “show” and painful rhythmic regular contractions. Madam Hannah was then appreciated for the warm reception and permission was sought to leave and next visit scheduled to be on the 25th November 2021 and was then seen off by client.

2.3 SUBSEQUENT ANTENATAL HOME VISIT

The next home visit was made on the 25th November, 2021 at 4:45pm. The aim of this visit was to know how the family was doing and also to ascertain if education on birth preparedness and complications readiness has been adhered to. On arrival, Madam Hannah was outside resting on a chair and her son was playing with other children outside. She was asked about her husband and she said he had gone to work. She was asked on how she was doing and she said she was doing well. Madam Hannah Boaa displayed her items for inspection and all were present. She said she had enough sleep during the night. She complained of constipation(altered bowel movement related to hormonal effects of pregnancy). She was encouraged to take in more fluids, fruits, roughages and vegetables.

She was educated on the need to deliver at the health facility to prevent complications like retained placenta and postpartum hemorrhage.

Education was made on perineal exercise to strengthen the muscles and also to continue taken her medications. Emphasis was laid on signs of true labour, thus show and painful uterine contractions and was encouraged to report to the clinic if she experiences these signs. She was also reminded to report to the clinic if she feels anything unusual, like bleeding.

She was reminded on the next visit to the clinic and permission was sought to leave.

2.4 SUBSEQUENT VISIT TO THE CLINIC

On 30th November, 2021, was the day scheduled for Madam Hannah Boaa's next visit to the clinic. She arrived at 9:30 am; she was offered a seat and welcomed warmly. Her vital signs were checked and recorded;

Temperature	37.2 degree Celsius
Blood Pressure	100/60millimeters of mercury
Pulse	88beat per minute
Respiration	19 cycle per unit

She granted permission to perform head to toe examination after it was explained to her. The purpose was to detect any abnormalities. She was asked to empty her bladder to promote comfort during which midstream sample was collected and tested for sugar and protein and results for both were negative. In the examination room, she was assisted to position herself in a supine position on the examination bed. Hand washing with soap and water was done. Head to toe examination was done and no abnormality was detected. On palpation, the gestational age was 38 weeks, Symphysio-fundal height was 37cm, lie -longitudinal, and presentation- cephalic, descent -5/5th, and fetal heart rate was 140bpm on auscultation. Her hemoglobin level was checked and recorded as 13.0gramme per deciliter. She was thanked and helped into a comfortable position on a chair. Hand washing was done and dried and findings were communicated to her. She was encouraged to report to the clinic if there are signs of true labour or if she encounters any problem. She was also encouraged to keep taking the routine drugs that were given to her previously.

On 2nd December,2021, client was visited to know how the family was doing and how client was coping with pregnancy. Although client's delivery time was supposed to be 27th November, 2021 but she had not given birth as at that time. So she was encouraged to calm

down because there is (plus two weeks minus two weeks) in the expected date of delivery. All items needed for delivery were packed. She complained of lower abdominal pains(altered body comfort related to descent of the fetal head during late pregnancy) and was told to call anytime it becomes unbearable for her.

2.5 NURSING CARE PLAN DURING ANTENATAL

PROBLEMS IDENTIFIED

1. 20th November, 2021 Frequency micturition

2. 20th November, 2021 Insomnia

3. 20th November, 2021 Loss of appetite

4. 25th November, 2021 Constipation

5. 15th November, 2021 Lower abdominal pains

SHORT TERM OBJECTIVES

1. Client will cope with frequency of micturition till 72 hours after delivery.
2. Client will be able to sleep for at least 4hours within 24 hours.
3. Client will be able to eat at least half plate of food served within 24 hours.
4. Client will regain bowel habit (1daily) within 48hours and cope with it.
5. Client will cope with lower abdominal pains within 48hours and cope with it throughout pregnancy.

LONG TERM OBJECTIVE

Madam Hannah will have a successful pregnancy, labour and puerperium outcome without any complications to her and her baby.

TABLE 1: NURSING CARE PLAN FOR ANTENATAL

Date / Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
20/11/21 4:30pm	Frequency of micturition related to descent of the presenting part.	Client will cope with frequency of micturition till 72 hours after delivery.	1. Reassure client 2. Explain the physiology of frequency of micturition to her. 3. Encourage client on the need to keep vulva clean and wear cotton under wears. 4. Encourage client to void every 1 – 2 hours. 5. Encourage her to have a pale close to her bedside when sleeping.	1. Client was reassured 2. The physiology of frequency of micturition was explained to the client. 3. Client was encouraged on the need to keep vulva clean and wearing of cotton under wears. 4. Client was encouraged to void whenever she feels the urge to. 5. Client was encouraged to use a pail at night rather than walking a distance to urinate	23/11/21 4:30pm	Goal partially met as client verbalized that she has now understood why she is urinating frequently and will try to cope with it.	JAB

TABLE 1: NURSING CARE PLAN FOR ANTENATAL CONTINUED

Date / Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
20/11/21 4:30pm	Alteration in sleeping pattern (insomnia) related to frequency of micturition.	3. Client will be able to sleep for at least 4hours within 24 hours. as evidenced by client verbalizing that she now has enough sleep.	1. Reassure client. 2. Explain the physiology of frequency of micturition to the client. 3. Encourage client to take a warm bath before sleeping. 4. Encourage her on the need to ensure good ventilation in her room to help her sleep. 5. Encourage her to have at least 2 hours' rest and sleep in the afternoon.	1. Client was reassured. 2. Physiology of micturition was explained to the client. 3. She was encouraged to take a warm bath before sleeping. 4. She was encouraged to ensure good ventilation in her room. 5. She was encouraged to have some sleep during the day.	21/11/21 4:30pm	Goal fully met as client reported that she can now have enough sleep.	JAB

TABLE 1: NURSING CARE PLAN FOR ANTENATAL

Date / Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
20/11/21 4:30pm	Altered nutritional pattern (loss of appetite) related to hormonal changes during pregnancy.	Client will be able to eat at least half plate of food served within 24 hours. as evidence by client verbalizing that she can eat half plate of food served.	1. Reassure the client that she will regain her normal eating pattern. 2. Educate client to practice good oral hygiene. 3. Encourage client to eat food in bits but frequently. 4. Encourage client to eat a preferred food. 5. Encourage client to take in more fruits to boost her appetite. 6. Encourage client to take in multivitamin as prescribed	1. Client was reassured that she will regain her normal eating pattern. 2. Client was educated to practice good oral hygiene. 3. Client was encouraged to eat food in bits but frequently. 4. Client was encouraged to eat a preferred food. 5. Client was encouraged to take in more fruits to boost her appetite. 6. Client was encouraged to take in multivitamin as prescribed.	21/11/21 4:30pm	Goal fully met as evidenced by client verbalizing that she can now eat half plate of food served.	JAB

TABLE 1: NURSING CARE PLAN FOR ANTENATAL

Date/ Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
25/11/21 10:00am	Altered bowel movement (constipation) related to hormonal effects of pregnancy	Client will regain bowel habit (1daily) within 48hours and cope with it as evidenced by client verbalizing that she is able to empty her bowel once within 48hours.	1 Reassure client. 2. Explain the physiology of constipation during pregnancy to the client. 3. Encourage client on intake of fruits, roughages and vegetables. 4. Encourage client on mild exercises like walking. 5. Educate client on the intake of more fluids	1. Client was reassured. 2. The physiology of constipation was explained to client. 3. Client was encouraged on the intake of fruits and vegetables to prevent constipation. 4. Client was encouraged on the need to exercise. 5. Client was educated on the intake of more fluids.	27/11/21 10:00am	Goal fully achieved as client said she was able to empty the bowel once within 48hours.	JAB

TABLE 1: NURSING CARE PLAN FOR ANTENATAL

Date / Time	Nursing Diagnosis	Nursing Objectives	Nursing Orders	Nursing Intervention	Date / Time	Evaluation	Sign
15/11/21 1:30pm	Altered body comfort (Lower abdominal pains) related to descent of the fetal head during late pregnancy	Client will cope with lower abdominal pains within 48hours.	1.Reassure client that the pain will be reduced. 2. Explain the physiology of the pain to her. 3. Give sacral massage. 4.Engage client in diversional therapy to relieve the mind of pain. 5. Encourage deep breathing exercise when in pain.	1. Client was reassured that the pain will be reduced. 2. Client was told the lower abdominal pain was as a result of descent of the presenting part. 3. Client was given sacral massage. 4. Client was engaged in a conversation during the labour to relieve her mind of pain. 5. Deep breathing exercise was done during contractions.	17/11/21 1:30pm	Goal partially met as evidenced by client verbalizing that she can now cope with the pains	JAB

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter talks about admission and first stage of labour, preparation for birth, management of second stage of labour, immediate care of the baby

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Hannah Boaa came to Agyei-Mensah Memorial Maternity Home accompanied by her husband on 4th December, 2021 at 4:40 am. They were welcomed and offered a seat. Madam Hannah Boaa complained of lower abdominal pains and painful uterine contractions. Client's antenatal book was glanced through for previous history and also to confirm expected date of delivery. At the first stage room, client was offered a bed, reassured and procedures to be done were explained to her and consent was sort. Client's vital signs were checked and recorded as follows;

Temperature	36.5 degree Celsius
Pulse	80 beats per minute
Respiration	18 cycles per minute
Blood pressure	110/60 millimeters of mercury

Client was served with a bedpan to empty her bladder and specimen taken, which tested negative for protein, and glucose. A total amount of 100mls of urine was emptied. Client was then helped into a bed, hands were washed and dried with a clean towel, and she was examined from head to toe and no abnormalities were detected. On abdominal examination, the shape was ovoid with normal size and there was linea nigra and striae gravidarum

presence. The gestational age was 38+5days while the symphysio - fundal height was 36cm. Upon palpation, the lie was longitudinal, presentation was cephalic, descent was $3/5^{th}$, fetal heart rate on auscultation was 140bpm. Before palpation, hands were warmed by rubbing in order to check for contractions. There were 3 contractions in 10 minutes lasting 22 seconds. Permission was sought to perform vaginal examination.

A tray was set containing a sterile glove, a gallipot with sterile cotton wool swabs and another gallipot with savlon, a sanitary pad and a receiver. Client was helped to assume a lithotomy position and was draped. Hands were washed thoroughly with soap under running water, hands were dried and sterile gloves were worn. The vulva was inspected for scar, rashes, warts, varicose veins and sores and nothing abnormal was detected. The vulva was then swabbed with five sterile cotton wool swabs soaked in savlon solution.

The vulva was swabbed from majora to the minora to the vestibule using a different swab at each time. The right hand is used to pick the sterile cotton and deposited in the left hand and the various sides of the majora and the minora is swabbed and the last cotton used for the vestibule. The middle finger was first inserted followed by the index finger were then inserted gently into the vagina. The condition of the vagina was warm, roomy and moist, cervix was soft and thin with dilatation of four (4) centimeters with membranes intact and moulding was zero (0). Ischial spines were blunt with a well curved sacrum, and a wide pubic arch. A fresh perinial pad was placed on the vulva and client was asked to lie on side (lateral position) to prevent supine hypotension syndrome. Gloved hands were dipped into 0.5% chlorine solution before removing. All findings and progress of labour was communicated to the client. The dilatation board was used to explain the cervical dilatation and progress of labour. Client was thanked for cooperating and all information gathered was recorded on a partograph.

PREPARATION FOR BIRTH

The midwife in charge who would supervise labour and delivery was identified as a skilled helper and she would also help in both care of the baby and mother. The unskilled helper that was identified was Mr. Appiah, Madam Hannah Boaa's husband, who will assist in time of need. A taxi was made available and the driver was informed that he would be called in case of emergency.

The delivery area was prepared for delivery with a source of light checked and portable flash light was made available. We informed her that prior to labour, all windows will be closed and her hands will be washed with soap under running water. Client complained of fatigue so liberal fluids were given to her to prevent her from getting dehydrated. Madam Hannah Boaa was assisted to wash her hands, her chest and abdomen and was then prepared for skin-to-skin care. Hands were washed with soap under running water. A dry, flat and safe space was prepared for baby to receive ventilation if needed. All equipment and supplies used for ventilation like the ventilation bag were tested if they were functioning properly. Rechargeable lamp was also on standby.

MANAGEMENT OF FIRST STAGE OF LABOUR

On arrival, it was observed client was anxious and was going through pains. Client was reassured of normal labour with a healthy baby without complications. She was advised to avoid pushing during contraction since the cervix was not fully dilated and to prevent edematous cervix. Bedpan was provided for her to empty the bladder frequently to enhance effective contraction and descent of the fetal head since full bladder could slow down progress of labour.

Client complained of nausea (having the urge to vomit because of the fluctuations of hormones) and was also prone to infection due to mishandling of the perineal pad so was educated on the importance of changing the pad when soiled and not to be touching the perineal area anyhow. Client was told to walk around for the fetal head to descend faster. The fetal heart rate, contraction and maternal pulse were monitored every thirty (30) minutes while blood pressure, dilatation of the cervix and descent of the fetal head were checked every four (4) hours and temperature checked every two (2) hours and recorded on the partograph.

At 8:50am, vagina examination was done and vagina was warm and moist, the cervix was eight (8) centimeters dilated and well applied to the presenting part, parietal bones were facing each other and sutures were easily felt, liquor was clear and moulding was 1+ with descent 1/5 and fetal heart rate was 140 beats per minutes, Contractions were four (4) in ten (10) minutes lasting fourty-five (45) seconds. Vital signs were checked and recorded as below

Temperature 36.2 degree Celsius

Pulse 70beat per minute

Respiration 22 cycles per minute

Blood Pressure 110/60 millimeters of mercury

The amount of urine emptied was hundred (100) milliliters. Client was made comfortable in bed by cleaning all discharges and a new perineal pad applied. All findings were documented on a partograph sheet.

At 10:45am, membranes ruptured spontaneously so another vaginal examination was done and the cervix was fully dilated (ten centimeters) which was confirmed by the midwife in-

charge and there was no cord prolapse, descent was 0/5, moulding was (++), contractions were four (4) in ten (10) minutes lasting sixty (60) seconds, fetal heart rate was 140 beats per minute and urine output was 100 milliliters. At 10:50am, client complained of bearing down sensation. Findings were recorded on the partograph sheet and client was informed of the full dilatation of the cervix. Client was made known that the baby would be delivered onto the abdomen to establish bonding. Delivery trolley already set was push to client's bedside to conduct delivery.

The top shelf contained the following items

Sterile delivery packs containing;

Two artery forceps

Oxytocin in syringe

Four clean towels

Two Gallipot with cotton wool swab and gauze respectively

One cord scissors

Lower shelf containing

Sterile gloves

Perineal pads

Receiver for placenta

Measuring jug

Receiver for used swabs

Identification band

Fethoscope

Antiseptic lotion

Bed pan

Mackintosh

Three clean cot sheet

Cord clamp

Lidocaine

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

Madam Hannah Boaa was assisted to assume the lithotomy position since that was her preferred position. Protective clothes were worn and hands were washed with soap under running water then dried with a clean towel. Sterile gloves were put on and delivery pack was opened by the midwife in-charge. The vulva was cleaned with savlon solution as well as the upper thighs. Clean towel was used to drape the thighs and buttocks. A sheet was placed on the abdomen and another was placed under the buttocks. Fetal heart rate was also checked and recorded as 135beats per minutes. She was encouraged to bear down(push) in expulsive stage and rest in between contractions. A fresh pad was applied to the perineum and the index and middle finger were placed on advancing head to aid flexion. Flexion of the head was maintained to allow the smallest diameter to distend the vulva. After the head crowned, she was asked to pant while the head was delivered by extension as the sinciput, face and the chin swept the perineum. The eyes, nose and mouth were cleaned. The neck was felt for cord around neck but there was none. Restitution and external rotation of the head took place allowing the shoulder ready to be born. The head of the fetus was held in both palms on each side of the bi-parietal bones and a downward traction was applied to allow the anterior shoulder slipped under the pubic bone. Upward traction was applied towards the mother's abdomen and the posterior shoulder was delivered. The baby was delivered by lateral flexion

onto the mother's abdomen. Time of delivery was 11:00am by the midwife in-charge. Baby was dried, the wet cloth was removed from mother's abdomen, she was dried before baby was placed on mother's bare abdomen and covered with dry warm cloths. This is to help in skin-to-skin contact as well as providing warmth and bonding between the mother and the baby. A healthy baby boy was delivered and sex confirmed by the mother. The breathing pattern of the baby was assessed while drying her and the APGAR score within the first minute was 8/10. The woman was congratulated for her cooperation. 10 units of oxytocin IM was given after ensuring that there is no undiagnosed twin in utero.

3.3 IMMEDIATE CARE OF THE BABY

Immediately the head was born, the baby's face was wiped with a sterile gauze swab and eyes were cleaned with sterile gauze from the inner canthus outwards. As soon as the rest of the body was delivered onto the mother's abdomen, the liquor was wiped off quickly from his body with a warm towel and place skin to skin with the mother to prevent hypothermia. The baby cried within the first minute of birth. The cord was clamped with two artery forceps. It was re-clamped with a plastic cord clamp 3cm away from the baby's abdomen and 2cm from the first clamp. The cord was cut in between the two cord clamp with a sterile scissors whiles covering it with a sterile gauze to prevent the splashing of blood. The first and fifth minute Apgar score was assessed and recorded as 8/10 and 9/10 respectively. Wet towels were replaced with warm dry towels. An identification band with mother's name, baby's sex, time and date of delivery was tied on the baby's wrist and he was put to breast.

APGAR score	1st minute	5th minute
Appearance	1	2
Pulse	2	2
Grimace	1	1
Activity	2	2
Respiration	2	2

3.4 ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR

Madam Hannah was in the lithotomy position and a receiver placed near the vulva in between the thighs. Procedure was explained to her. After the delivery of the baby, the uterus was palpated to rule out the presence of an undiagnosed 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 was 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 pressure to prevent uterine inversion during removal of the placenta. At the same time, the dominant hand that held the clamped cord was pulled gently in a downwards traction. With steady controlled cord traction, the process was repeated until the placenta was visible at the vulva and cupped with the two hands, and was rolled round to gently tease the membranes. The placenta was completely delivered at 11:05am. A quick examination of the

placenta was made where both the maternal and fetal surfaces were intact and membranes were also intact with no missing lobe. The placenta was placed in a receiver for thorough examination later. The uterus was rubbed for contraction and clots were expelled. The client was taught how to massage the uterus. The vulva was cleaned with savlon, the labia were patted and cleaned. Two sterile gauze were wrapped on the middle and index finger for inspection and there were no lacerations on the perineum. With a gloved hand, the vaginal wall and cervix were inspected but there were no tears. The total blood loss was 150 milliliters. Client was cleaned and a new perineal pad was applied to the vulva to absorb any lochia and client was congratulated**.**

3.5 EXAMINATION OF THE PLACENTA AND MEMBRANES

It was placed on a flat surface for inspection. Firstly, the umbilical cord had two arteries and a vein with no knot, the umbilical cord was situated at the center of the fetal surface and blood vessels were radiating outward. The fetal surface was bluish grey in color. The umbilical cord was held upward to bring the membranes down; the placenta was placed on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed. The maternal surface was examined by cupping the placenta in the hand, there was no infarct, the color was reddish brown and the lobes were intact. Membranes were also intact. After the examination, hands were dipped in chlorine solution before discarding the gloves. The instruments were also decontaminated in 0.5% chlorine solution for 10 minutes. She was encouraged to urinate frequently for the uterus to contract and was told that if she should feel any changes, she should not hesitate to report. She was told that she would be taken to the lying in and observed for the next six hours. All findings were recorded on the partograph.

EXAMINATION OF THE NEW BORN

The procedure was explained vividly to the client, examination gloves were worn and the baby was examined 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 colour was noted and covered again to be examined from hair to toe.

On examination of the head, the sutures and fontanels were examined with no abnormality detected. There was no laceration on the scalp and no caput succedaneum as well. The head circumference was measured and it was 35 cm. The pinna of the ears were well formed and there were no discharges from the ear. The eyes were in alignment with the ears. There was no pallor of the conjunctiva or jaundice on the sclera. The nose was well formed with septum dividing it. Nose was patent with no discharges. 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 were no enlargement of lymph nodes and swelling of the neck.

On breast examination, there was no engorgement of the breast. The nipple was at the center of the areolar. There was no distention of the abdomen, enlarged spleen or liver as well as bleeding of the cord. There were three blood vessels that run through the cord which indicated two arterial cord vessels and a cord vein. The spine was examined with the baby lying in prone position. The back was palpated for swellings, spinal bifida or a missing vertebra, meningomyelocele but there was none. The skin was examined for skin colour, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark. There were no abnormalities with some amount of vernix caseosa. The upper extremities were equal with no extra digits. There were palmer creases and no webbed fingers. Grasping and Moro reflexes were present.

The lower extremities were also equal without an extra digit. Both legs were examined with no talips and congenital dislocation of the hip. Knee flexes were normal.

On inspection of the genitalia, the penis and scrotum was inspected for rashes and there were no abnormalities noticed. Baby passed meconium and urinated soon after birth indicating the patency of the anus and urethra.

3.6 MANAGEMENT OF FOURTH STAGE OF LABOUR

The mother and baby were assessed every 15 minutes for two hours and 30 minutes for the next one hour. Vital signs for the baby was checked and recorded as follows;

Temperature	37.0^{o}C
Apex beat	130bpm
Respiration	40cpm

The mother's vital signs for every 15 minutes for the first 2 hours ranged from:

Temperature	36.5 - 36.9^{0}C
Pulse	75 – 85 beats per minute
Respiration	18 – 20 cycles per minute
Blood pressure	110/60 - 120/80 millimeter of mercury

The uterus was massaged to ensure that it was well contracted and client was encouraged to massage her uterus. She was encouraged to report any unusual bleeding. Symphysio fundal height was 17 centimeters. The Lochia was also checked, with its color being red (rubra) and not offensive. She was again encouraged to empty her bladder frequently to prevent postpartum hemorrhage and also to change soiled pads frequently to prevent infections. She

was educated to wash her hands with soap under running water after changing her pad and also before and after attending to the baby. She was also assisted to fix baby to breast, and made known about the importance of exclusive breastfeeding for the first six months. Madam Hannah Boaa and her baby were sent to the lying in after delivery for further monitoring of both mother and baby. Client husband was allowed to see her and she was served with warm porridge and bread to restore energy. General condition of client and baby was satisfactory and all labour notes were recorded on the partograph sheet.

PREVENTION OF INFECTION

Immediately the baby was born, the eyes were cleaned from inner canthus to the outer. Hands were washed and dried before handling the baby. Chloramphenicol eye drop was instilled on the eye as prophylaxis against eye infection. Attention was paid to the cord by cleaning it with sterile cotton soaked with chlohexidine and kept dry to prevent infections. She was reminded to wash her hands under running water before and after handling the baby.

3.7 SUMMARY OF LABOUR

Time of delivery 11:00am

Time of placenta expulsion and membranes 11:05am

Type of delivery Spontaneous vaginal delivery

Estimated blood loss 150mls

Duration of labour

First stage of labour 6 hours

Second stage of labour 10 minutes

Third stage of labour 10 minutes

Total duration of labour 6hours 20minutes

CONDITION OF MOTHER

Blood pressure	110/70 mmHg
Pulse	84 beat per minute
Temperature	36.4degree Celsius
Fundal height	17centimetres
Uterus	Contracted
Lochia	Red (rubra)
Perineum	Intact
Estimated blood loss	150mls
Condition	Satisfactory

CONDITION OF BABY

Apgar score of 1st minute 8/10

Apgar score of 5th minutes 9/10

Sex	Male
Temperature	36.8 degree Celsius
Birth weight	2.9kilograms
Apex heart beat	130 beats per minute
Respiration	35 cycles per minute
Length of the baby	47 centimeters
Head circumference	33 centimeters
Meconium	Passed
Urine	Passed
Abnormalities	None detected
Condition	Satisfactory

3.8 NURSING CARE PLAN DURING LABOUR

Madam Hannah Boaa complained of

1. Lower abdominal pains
2. Client complained of fatigue
3. Client was prone to infection due to mishandling of perineal pad
4. Client was anxious
5. Client was nauseated

SHORT TERM OBJECTIVES

1. Madam Hannah Boaa will cope with lower abdominal pains within 3 hours.
2. Client s fatigue will subside within 12hours.
3. Client will be free from infection within 48hours
4. Clients anxiety will resolve within an hour.
5. Client will be relieved of nausea within an hour.

LONG TERM OBJECTIVES

Madam Hannah Boaa will go through all the stages of labour successfully without any form of complications to the mother and the baby.

TABLE 1: NURSING CARE PLAN ON LABOUR

Date / Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
4/12/21 4:35am	Lower abdominal pain related to descent of the fetal head	Client will cope with lower abdominal pains within 3 hours as evidence by client verbalizing that she is able to cope with pain and midwife witnessing client coping with pain.	1. Reassure client that the pain will be reduced 2. Explain the physiology of the pain to her 3.Give sacral massage 4. Engage client in diversional therapy to relieve the mind of pain. 5. Encourage client on ambulation .	1. Client was told her condition is temporal and the pains will reduce. 2.Client was told the lower abdominal pain was as a result of descent of the presenting part 3. client was given sacral massage 4. Client was engaged in conversation during the whole period of labour to relieve her mind of pain. 5. Client was encouraged to walk around	4/12/21 7:35am	Goal fully met as client reported that she will cope will cope with pain midwife witnessing client was able to cope with pain	JAB

TABLE 2: NURSING CARE PLAN ON LABOUR CONTINUED

Date / Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
4/12/21 5:35am	Fatigue related to stresses of labour	Client will be relieved of fatigue 12 hours after delivery evidence by client verbalizing that the fatigue has subsided and the midwife visualizing that client has smiling facial expression.	1. Encourage client to take oral fluids to hydrate her. 2. Encourage deep breathing exercise when in pain. 3. Encourage client to stop screaming and conserve energy 4. Encourage client to pant and relax in between contractions. 5. Give emotional and physical support throughout labour 6. Provide client with a conducive atmosphere and bed for client to rest.	1. Oral fluid (fruit juice) was given to the client to hydrate her. 2. Deep breathing exercise was done during contractions 3.Client was encouraged to stop screaming and conserve energy and she did 4. She relaxed in- between contractions. 5.Client was given emotional and physical support throughout labour 6. Conducive atmosphere and bed was provided for client to rest.	4/12/21 5:35pm	Goal fully met as client said that she was no longer exhausted and midwife observed no signs of fatigue.	JAB

TABLE 2: NURSING CARE PLAN ON LABOUR CONTINUED

Date / Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
4/12/21 4:35am	Potential for infection related to mishandling of perineal	Client will be free from infection within 48hours as evidenced by the client showing no signs and symptoms of infections	1.Reassure client that she will be free from infection 2. Encourage her to change perineal pad when soaked 3. Encourage client to perform proper hand washing before and after changing touching pad 4. Encourage client to use new pad when it falls	1. Client was reassured that she will be free from infection. 2. She was encouraged to change pad when soaked 3. Client was encouraged to perform proper hand washing before and after changing pad. 4. Client was encouraged to use new pad when it falls	6/12/21 4:35am	Goal fully met as midwife reported that client did not show any signs of infection	JAB

TABLE 2: NURSING CARE PLAN ON LABOUR CONTINUED

Date / Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
4/12/21 4:35am	Anxiety related to unknown outcome of labour	Client will be relieved of anxiety within an hour of labour as evidence by midwife observing client with relaxed looks. Client verbalizing that she is no more anxious.	1. Reassure client about the competency of the staff and the outcome of labour. 2. Explain every procedure to be carried to her to allay her anxiety and fear. 3. Educate her on the outcome of labour to make her feel less anxious. 4. Encourage deep breathing exercise to make client feel comfortable and relieve her of anxiety. 5. Encourage client to ask questions and answer them.	1.Client was told of the caliber of the staff on duty and they were introduced to her 2. Client was told before timing contractions or listening to fetal heart rate. 3.Client was told the finding of each examination 4.Client performed deep breathing exercise during uterine contractions 5.Client asked questions on the outcome of contraction and answers was given tactfully	4/12/21 5:35am	Goal achieved as midwife reported that client was relaxed in bed. Client said she was no more anxious.	JAB

TABLE 2: NURSING CARE PLAN ON LABOUR CONTINUED

Date/Time	Nursing Diagnosis	Nursing Objective	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
4/12/21 4:35am	Nausea related to expulsive uterine contractions.	Client will be relieved of nausea within 1hour as evidenced by, 1.client reporting that she is coping with the nausea 2.midwife observing that client complains less	1. Reassure client that nausea will subside. 2. Educate client on the causes of nausea. 3.Encourage client to eat light foods. 4. Keep room well ventilated.	1.Client was reassured that nausea will subside. 2. Client was educated on the causes of nausea. 3. client was encouraged to eat light foods in bit. 4. Environment was kept clean and free from nauseated substance.	4/12/21 5:35am	Goals fully met as client reported that her nausea has subsided .	JAB

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

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

4.1 DAY OF DELIVERY

On 4th December, 2021 Madam Hannah Boaa was cleaned and transferred to the lying-in ward at 11:50am after skin to skin. She was served with porridge and bread. She was educated on the need to empty her bladder to prevent post-partum hemorrhage. Symphysio-fundal height was 17 centimeters. Her first vital signs were checked and recorded as follows.

MOTHER'S VITAL SIGNS

Temperature	36.6 degree Celsius
Pulse	80 beat per minute
Respiration	20 cycles per minute
Blood pressure	110/60 millimeters of mercury

The vital signs were checked for every 15minutes for 2hours, 30minutes for 1hour and 1hour for 3hours.

Lochia was bright red (rubra) and flow was minimal. Perineum was intact an mother was educated to massage her uterus and report any bleeding per vaginum. She was educated to breastfeed baby on demand or 1-3 hourly or 8 to 12 times daily to ensure adequate feed and to serve as a method of family planning and also increase bonding. She was told to change perineal

pad frequently and wash hands before breastfeeding the baby and after attending natures call. Head to toe examination was done and no abnormalities were detected. She was asked to take her bath.

4.2 SUBSEQUENT CARE OF THE BABY

Baby was bathed six hours after delivery, procedure was explained to mother and all items used for the procedure were assembled as below;

BABY BATH

REQUIREMENTS

TOP SHELF

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

Cord dressing tray (cotton)

BOTTOM SHELF

Soap

Sponge

Cream/ powder

Basin

Towels: 1 big towel and 3 small ones

Baby cot sheet

Apron

Gloves

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

Mackintosh

2 jugs containing hot and cold water each

Two receptacles for used water and dirty linen

A receiver for used swab

Methylated spirit for cord dressing

PROCEDURE

A plastic apron was put on. Hands were washed with soap and water and dried with clean towel. The hot water was poured first and the cold was added. The mother of the baby was asked to check the temperature of the water. Examination gloves were worn and the baby was put on a safe flat surface and was undressed. Baby was then wrapped with a cot sheet and examined thoroughly. The head was exposed for it to be bathed. The eyes were cleaned (wiped) with clean cotton wool swabs soaked in clean water and the face cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand. The head was supported and the baby's ears plugged with two fingers. The head was then washed with soapy sponge. Baby was then put on protected flat surface and exposed. The arms and front of trunk were washed paying attention to the skin folds. Then baby was turned with one arm supporting the chest with one hand holding the distal arm of the baby. The back was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in a bath of warm water. He was then placed on the flat surface covered by a bath towel. A small towel was used to dry baby, paying attention to the skin folds. Baby oil as well as powder was applied on the baby. A diaper was put on and the baby dressed and wrapped with cleaned cot sheet.

CORD DRESSING

A tray was set aside containing (sterilised gallipot, cotton wool swab and methylated spirit). Procedure for dressing the cord was explained to the mother and procedure performed in her presence. Hands were washed with soap and water and dried with a clean towel. Sterile gloves

worn and cord exposed. The cord was inspected for bleeding and the tip of the cord held with a swab. The skin around the base of the cord was cleaned 5cm away from the base with sterile cotton wool with methylated spirit and then discarded. The whole cord was clean with sterile cotton wool and methylated spirit from the base upwards once at each side of the cord (front and back) and the tip clean with separate sterile cotton wool swab soaked with methylated spirit and cord left exposed. Hands were immersed in 0.5% chlorine solution, gloves removed and disposed. Hands were washed and dried with towel. Baby was then dressed and given to the mother to breastfeed. Client was advised to use only the sterile cotton wool swab and methylated spirit given to her to dress the cord and always keep the cord exposed after dressing, she was told to apply dipper below the umbilicus.

Mother was encouraged to maintain baby's temperature to prevent the baby becoming too cold or too hot by dressing baby with clothing before wrapping her. Mother was encouraged to breastfeed baby exclusively for 6months and on demand or 8 to 12 times a day. Client was also educated on breastfeeding problems and how she would manage the problem like breast engorgement, sore nipple and cracked nipple and to report if problem persist. Mother was advised to use only prescribed drug for cord care. Client was advised to wash hands before and after handling the baby. All findings were communicated to the mother and recorded afterwards.

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

BABY'S VITAL SIGNS

Temperature	36.9 degree Celsius
Apex heart rate	134 beat per minute
Respiration	42 cycles per minute
Weight	2.9kilogram

4.3 FIRST DAY POST DELIVERY AND DISCHARGE

The first day post-delivery was on 5th December, 2021 at 7:30am. Client woke up looking strong and healthy. Client brushed her teeth and was assisted to take her bath. Client was served with porridge and bread by her mother in-law. Head to toe examination was done and no abnormalities were detected on both mother and baby. Baby was bathed and cord dressed in the presence of the mother. Client was taught how to dress the cord with six cotton wool swabs soaked in methylated spirit. Client complained of after pain and was encourage to empty her bladder whenever she has the urge. Client also complained of unable to eat. Symphysio-fundal height was 16centimeters. First day post-partum check done on client and recorded as follows:

Mother's vital signs;

MORNING

Temperature	36.5 degrees Celsius
Pulse	81 beat per minute
Respiration	19 cycles per minute
Blood pressure	110/65 millimeters of mercury

Lochia was bright red with small flow and also not offensive. The baby passed meconium and urine. No abnormalities detected on head to toe examination. Weight was 2.9kilograms.

Baby's vital signs were;

	MORNING
Temperature	37.1 degree Celsius
Apex heart beat	134 beat per minute
Respiration	44 cycles per minutes
Weight	2.9kg

The baby was re-examined head to toe and confirmed by the midwife in charge to exclude any abnormality of the baby before discharge. Baby was dressed nicely in a warm and clean baby

sheet and handed over to her mother for breastfeeding. A demonstration on how to position and attach the baby during breastfeeding was done in the presence of the mother. Bacillus Calmette Guerin (BCG) and polio 'O' was given to the baby.Client was educated not to apply anything at the site of injection and educated to report on danger signs of the baby such as fever, difficulty in breastfeeding and breathing problems. Client was asked to come along with the baby for the rest of the immunization at the time scheduled in order to prevent baby from childhood preventable diseases. Client was assisted to pack her belongings because she would be discharged home. Education was given to her on how to take the medications ordered for her. Client was served the following drugs per hospitals protocol:

Tablet metronidazole 400mg three times daily x 7 days

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

Tablet folic acid 5mg once daily x 30days

Tablet paracetamol 1g three times daily x 5days

Client was told she would be visited at home to provide care for her and baby. Client was also reminded to come for one-week postnatal care on 14th December, 2021. Client was reminded to do exclusive breastfeeding, recognizing and management of common breast feeding problems like breasts engorgement. She was educated on proper hand washing (washing hand with soap under running water) before and after each feed which is a way of helping to prevent infections. The mother was educated to complete immunization schedule. Client was taught to eat well balanced meal, fruits to enhance in the prevention of constipation. Client was told to change her perineal pad every 4 hours or when soiled, proper disposal of it and hand washing after removing the pad. Client had registered with the National Health Insurance scheme so her bills were taken

care off. Her husband was advised to give support to the wife in the care of the baby and the other children. All documents were signed and recorded. At 9:00 am, client was discharged and was reminded that she would be visited at home the next seven (7) days continuously to ascertain the progress of the mother, baby and the entire family. She thanked all the staff and also bid farewell to the other clients at the ward. She was accompanied to the junction with her husband and board their car home.

4.4 FIRST POSTNATAL HOME VISIT

In the evening a visit was made to her house at 4:00pm and mother and baby was doing well. Baby was top and tailed paying attention to the skin folds and the general examination was carried out, no abnormality was found. The cord was aseptically dressed with methylated spirit and no abnormality was detected and baby was doing well. The baby had already passed stools and urine.

OBSERVATION ON MOTHER (5th December, 2021)

	EVENING
Temperature	37.0 degree Celsius
Pulse	79 bpm
Respiration	18 cpm
Blood pressure	100/60mmHg
Fundal height	16 cm
Condition of the uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY(5th December, 2021)

	EVENING
Temperature	36.7 degree Celsius
Apex heart beat	136 bpm
Respiration	45 cpm
Weight	2.9 kg
Cord bleeding	No
Suckling	Yes
Stool colour	Meconium

4.5 SECOND POSTNATAL HOME VISIT

On 6th December, 2021, the second visit was made to client's house at 7:00am and 4:00pm respectively. The baby was also doing well. Permission was sought to inspect her perineal pad and the lochia was, red (Rubra) and not offensive. The head to toe examination was also done and everything was normal. The symphysio fundal height was 15cm.

The baby was toped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was neatly dressed with no abnormality detected and was getting dried. The baby passed stools and urine everyday according to Madam Hannah, baby weight was 2.8kilograms. She was educated to feed the baby on demand and adequately prior to bed time. Concerning the backache, a demonstration on proper position of the baby during breastfeeding was done in the presence of the husband.

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

OBSERVATION ON MOTHER (6th December, 2021)

OBERVATION	**MORNING**	**EVENINIG**
Temperature	36.9 ^{0}C	36.5C
Pulse	88 bpm	90 bpm
Respiration	19 cpm	18 cpm
Blood pressure	100/60mmHg	110/60mmHg
Lochia	Rubra	Rubra
Fundal height	15cm	15cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

OBSERVATION ON BABY (6th December, 2021)

OBERVATION	MORNING	EVENING
Temperature	37.0^{0}C	36.6C
Apex heart beat	135 bpm	134 bpm
Respiration	45 cpm	44 cpm
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Clean and dry	Clean and dry
Suckling	Yes	Yes
Weight	2.8 kg	2.8kg
Stool Colour	Meconium	Meconium

4.6 THIRD POST NATAL HOME VISIT

On 7th December, 2021, at 7:30am and 4:30pm, Madam Hannah was visited in her house. She was asked how she and her baby were doing after exchanging greetings, she said her condition was getting better and her previous complaints had improved and she also said that the baby was feeding and sleeping well. The husband was much pleased to be visited. Explanation was given to Madam Hannah was told that her and the baby were going to be examined from head to toe to detect any abnormality for early treatment. The client's conjunctiva was examined and there was no pallor, the breasts were firm, soft and were lactating well, the uterus was well contracted and

the symphysio fundal height measured 14cm. The perineum was clean when inspected, the lochia was Rubra with moderate flow and without odour.

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

Baby was examined from head to toe and no abnormality was found. He was not jaundiced and pale. Baby's weight was checked and recorded as 2.7kilograms. Baby's vital signs were taken and recorded as follows;

Assessment made was;

OBERVATION ON BABY (7th December, 2021)

OBERVATION	MORNING	EVENING
Temperature	37.0^0c	36.8^0c
Apex heart beat	130 bpm	136 bpm
Respiration	40 cpm	43cpm
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Drying	Drying
Suckling	Yes	Yes
Weight	2.7 kg	2.7 kg
Stool Colour	Meconium	Meconium

OBSERVATION ON MOTHER (7th December, 2021)

OBSERVATION	MORNING	EVENING
Temperature	36.8	36.4
Pulse	78 bpm	74 bpm
Respiration	20 cpm	19 cpm
Blood pressure	110/70mmHg	110/60mmHg
Lochia	Rubra	Rubra
Fundal height	14cm	14cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

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

4.7 FOURTH POSTNATAL HOME VISIT

On the 8th December, 2021, the fourth home visit was made to Madam Hannah's house at 7:00am and 4:20pm. Greetings were exchanged. Mother and baby were doing well. Permission was sought to inspect client's perineal pad and it was pink, scanty flow without any offensive smell. Client complained of not able to lactate well (breast engorgement). Client was told to

frequently feed baby on demands. Symphysio fundal height was 13 centimeters when measured. Her vital signs were checked and recorded as follows;

Baby was toped and tailed paying attention to the skin folds and general examination was carried out and no abnormality was present. The cord was dressed aseptically with no abnormality detected. The baby also passed stools and urine. Weight was 2.7kilogram.

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

OBSERVATION ON MOTHER (4th DAY POSTPARTUM)

	(8th December, 2021)	
OBSERVATION	**MORNING**	**EVENING**
Temperature	37.0^0C	$36.2\ ^0$C
Pulse	76 bpm	78 bpm
Respiration	21 cpm	19 cpm
Blood pressure	100/60mmHg	110/65mHg
Lochia	Serosa	Serosa
Fundal height	13cm	13cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

OBSERVATION ON BABY (4th DAY POSTPARTUM)

	8th December, 2020)	
OBSERVATIONS	**MORNING**	**EVENING**
Temperature	36.7^0C	36.6^0C
Apex heart beat	131 bpm	132 bpm
Respiration	39 cpm	43 cpm
Skin Colour	Pink	Pink
Cord bleeding	No	No
Cord	Shrinking	Shrinking
Suckling	Yes	Yes
Weight	2.7kg	2.7kg
Stool Colour	Yellowish	Yellowish

4.8 FIFTH POSTNATAL HOME VISITS

The fifth home visit was made to Madam Hannah's house at and 8:00am on 9th December, 2021. The health status of mother was inquired and she said the pain in her breasts had subsided except the fullness. Lochia was pink (serosa) with scanty flow without odour on inspection. Head to toe examination was done and everything was normal. Symphysio fundal height was measured and it was 12 centimeters.

Baby was top and tailed paying attention to the skin folds and the general examination was carried out, no abnormality was found. The cord was aseptically dressed with methylated spirit and no abnormality was detected and baby was doing well. The baby had already passed stools and urine. His weight was 2.8 kilograms when checked. Baby's stool was bright or mustard yellow. She complained of heaviness in the breast which was as a result of fullness. Client was educated to continue breastfeeding the baby on demand and frequently, and to apply warm compress on them to reduce the pain and was asked to breastfeed baby on demand and to make sure one breast is

emptied before the other and to wear well-fitting brassier.

She was encouraged to breastfeed the baby on demand and to ensure adequate warmth to baby. During the visit, client was educated to take nutritious meals and to take in fruits in addition since she was prone to getting infections.

OBSERVATION ON MOTHER (9th December, 2021)

	MORNING
Temperature	36.2^0C
Pulse	78 bpm
Respiration	20cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	12 cm
Condition of Uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY

(9th December, 2021)

	MORNING
Temperature	37.0^{0}C
Apex heart beat	136 bpm
Respiration	43cpm
Skin colour	Pink
Cord bleeding	No
Condition of cord	Shrinking
Suckling	Yes
Weight	2.8 kg
Stool colour	Yellowish

4.9 SIXTH POSTNATAL HOME VISIT

The sixth postnatal home visit was on 10th December, 2021 at 8:30am. Greetings were exchanged with client and her family after which a seat was offered in client's room. Mother and baby were both in a healthy condition and when it was inquired. She was reassured and was advised to breastfeed baby regularly. Inspection of the lochia was done and the colour was pink (serosa) without any bad odour and flow was scanty. After the head to toe examination, no abnormality was detected. Symphysio fundal height was 11 centimeters when checked.

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

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

OBSERVATION ON MOTHER

OBERVATION	**6th day (10th December,2021)**
	MORNING
Temperature	36.5^0C
Pulse	76 bpm
Respiration	20 cpm
Blood pressure	110⁄65mmHg
Lochia	Serosa
Fundal height	11cm
Condition of the uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY

OBERVATION	**6thday (10th December, 2020)**
	MORNING
Temperature	36.5^0C
Apex heart beat	129 bpm
Respiration	42 cpm
Skin Colour	Pink
Cord bleeding	No
Cord condition	Shrinking
Weight	2.9kg
Suckling	Yes
Stool Colour	Yellow

4.10 SEVENTH POSTNATAL HOME VISITS

The last home visit was made on 11th December, 2021 at 7:45am. Greetings were exchanged with client and her family and a seat was offered in client's room. Mother and baby were both in a healthy condition and Madam Hannah said the baby's cry had minimized and now sleeps a lot. On head to toe examination, no abnormalities were detected. Her breast was soft and lactating well. Inspection of the lochia was done and the colour was (Serosa) flow was very scanty

without any bad odour. Measurement of symphysio fundal height was 10 centimeters when checked. Client moved her bowel as well as that of the baby.

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

Client complained of backache and also educated on positioning of herself and baby during breastfeeding. Education was given to her on the importance of ensuring good personal hygiene and the need to feed the baby continuously on demand and at midnight too. Client said she appreciated that a lot, and client was thanked for her co-operation.

MOTHER

OBERVATION ON MOTHER	**7^{th}day (11th December, 2021)**
	MORNING
Temperature	36.2^{0}C
Pulse	78 bpm
Respiration	21cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactating

OBSERVATION ON BABY

OBERVATION	**MORNING**
Temperature	36.7^0C
Apex heart beat	132 bpm
Respiration	44cpm
Skin Colour	Pink
Cord bleeding	No
Cord condition	Off
Weight	3.0 kg
Suckling	Yes
Stool Colour	Yellowish

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Hannah came to the postnatal clinic on 14th December, 2021 at 9:40am and was offered a seat. Client said her family was doing well when asked. Every procedure to be done was explained to her to gain her consent. Her weight was 65 kilograms when checked and symphysio-fundal height was palpable. Vital signs were checked and recorded as follows:

Temperature	36.4 degrees Celsius
Pulse	80 beat per minute
Respiration	18 cycles per minute
Blood pressure	100/65 millimeters of mercury
Lochia	Alba

She was asked to take specimen of urine as she went to empty bladder. Her urine was tested and it was negative for both protein and sugar. Hemoglobin level was 12.5 grams per deciliter. Privacy was provided and she was helped onto the examination bed and head to toe examination was performed. Client's hair looked very nice, the eyes and nose were inspected and no abnormality was found. The conjunctiva was neither pale nor jaundiced. Breasts were examined but there was no abnormal mass, soreness of the nipples, engorgement present. The upper and lower extremities were inspected and no abnormality was present. On abdominal examination, the spleen was not enlarged, there was no tenderness after palpating the liver. The vulva was examined for infection, and lochia flow was Alba. No abnormality was found in all. Findings were communicated to Madam Hannah and was commended for her cooperation and she was also thanked as well.

Baby was also examined from head to toe. The conjunctiva was not pale; neither was there jaundice of the sclera nor eye discharges. The ears and nose were inspected as well as the lips and mouth, but no abnormality was found. The cord was off and the stump was healing neatly.

Baby's Vital signs were checked and recorded as follows:

Temperature	36.9 degree Celsius
Apex heart beat	128 beat per minute
Respiration	40 cycles per minutes
Weight	3.1kg

After the examinations, findings were communicated to Madam Hannah that nothing abnormal was detected on the baby. Client was educated on family planning, to help her and the husband space their birth and give birth to the number of children they could cater for. Madam Hannah was also reminded on the need to completely attend baby clinic to complete the child's immunization schedules. Client was asked to also attend six weeks' post-natal clinic for examination. Client was handed over to the Midwife-In Charge for continuity of care.

4.12 SECOND POST NATAL VISIT TO THE CLINIC

According to the midwife in charge, on the 13th January, 2022 Madam Hannah came to the clinic for six weeks visit. They were warmly welcome and they all looked very healthy. General examination was conducted on the client from head to toe as well as vital signs after her permission was sought. Her vital signs were checked and recorded as follows:

Temperature 36.4ºC

Pulse 78bpm

Respiration 20cpm

Blood Pressure 110/70mmHg

Madam Hannah Boaa was given a urine sample container to provide some urine to be sent to the laboratory for urine analysis to be performed. She was educated on the need and procedure to provide midstream urine for the examination. A sample of blood was also taken from Madam Hannah with her consent to be sent to the laboratory for her haemoglobin level to be tested. The results were explained to her as follows;

Haemoglobin	12.1 g/dl
Urine protein	Negative
Glucose	Negative

Madam Hannah was sent to the palpation room where privacy was provided by drawing the curtains and closing doors and windows. She was helped to lie on the examination bed. Hands were washed with soap under running water and dried with a clean dry towel.

Head to toe examination was done on her. On the head, hair was neat and well styled. The conjunctiva was pink and there were no discharges from the eyes, nose and ear. No abnormality was found on the mouth and neck. On the breast, no abnormalities such as sore nipple, engorgement, cracked nipple and mastitis were detected and the breasts were lactating well. On examining the abdomen, no abnormality such as sub involution, tenderness, enlargement of liver and spleen was detected and uterus was not palpable. With the lower extremities, certain condition such as oedema was looked out for. It was detected that she showed no abnormality.

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

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

Temperature	36.2°C
Respiration	34cpm
Apex heart beat	134bpm
Weight	5.1kg

Madam Hannah Boaa and her baby were handed over to the child welfare clinic and family planning unit for the six weeks' immunization against diphtheria, pertussis, tetanus, haemophilus influenza and hepatitis B. She was educated on family planning methods and she chose combined oral contraceptive.

She was encouraged to ask questions but she had none and no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutritious diet, which would help in lactation. She was finally referred to the public health nurse for continuity of care but to report to the facility anytime she encounters any health related problem. She was thanked for her co-operation and understanding.

4.13 CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED DURING PUERPERIUM

1. Client complained of backache

2. Client complained of after pain

3.. Client complained of inadequate sleep

4.Client complained of constipation

5.Client complained of breast engorgement

SHORT TERM OBJECTIVES

1. Client will be relieved of backache within 24 hours
2. Client's after pain will subside within 24 hours

3. Client will be able to sleep at least 6hours within 24 hours

4.Client will be able to pass stools at least once within 24 hours.

5.Clients breast engorgement will subside within 48 hours

LONG TERM OBJECTIVES

Client and baby will go through puerperium successfully without any complication.

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
06/12/21 8:30 am	Backache related to poor body posture during breast feeding	Client will be relieved of backache within 24 hours as evidenced by; 1.client verbalizing that her backache has been relieved.	1. Reassure client by explaining physiology to her to allay fear. 2. Demonstrate to client on how to position herself when breast feeding. 3. Encourage client to wear a well-fitting brassiere. 4. Encourage client to support her back with pillows when sitting. 5. Serve prescribed analgesics (paracetamol)	1. Client was reassured that she will be relieved of the pains. 2. A demonstration was done on how to position herself when breastfeeding such as 3. Client was encouraged to wear a well-fitting brassier. 4. Client was encouraged to support her back with pillows when sitting. 5. Paracetamol 1g was served as prescribed	07/12/21 08:30 am	Goal fully met as client verbalized that her pain is relieved.	JAB

PUERPERIUM CARE PLAN CONTINUED

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
07/12/21 07:30 am	After pain related to involution of the uterus	Client's after pain will subside within 24 hours as evidenced by 1.Client verbalizing that the pains have reduce. 2.midwife visualizing that client is showing a good facial expression.	1.Reassure client that the pain is temporal. 2.Reason of after pain should be explained to the client. 3. Encourage client to adopt a comfortable position when breast feeding. 4. Encourage client to empty her bladder whenever she has the urge. 5. Serve analgesics as prescribed. E.g. paracetamol	1. Client was reassured that the pain is temporal. 2. It was explained to the client that her pain was due to the involution of the uterus that is the uterus returning back to it non pregnant state. 3. She was encouraged to adopt a comfortable position when breast feeding. 4. Client was encouraged to empty her bladder whenever she has the urge. 5. Client was served with tab paracetamol1g tds x3	08/12/21 07:30 am	Goal achieved as 1.client reported that her pain has been reduced. 2.Midwife verbalized that client showed a good facial expression.	JAB

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
06/12/21 7:30am	Interrupted sleeping pattern (insomnia) related to frequent breastfeeding at night	Client will have a normal sleeping pattern of 6 hours within 24hours as evidenced by client verbalizing that she can have adequate sleep .	1. Reassure client that baby demand is important so she should be assisted. 2. Encourage client to have enough sleep during the daytime when baby is asleep 3. Encourage client to feed baby adequately before going to bed. 4. Educate client ‘s relative to help in taking care of the baby. 5. Encourage client and family to reduce the number of visitors.	1. Client was reassured that baby demand is important so she will be assisted. 2. client was encouraged to have enough sleep during the daytime when baby is asleep. 3. Client was encouraged to feed baby adequately before going to bed to make sure baby is well fed to sleep well. 4. client’s relative helped her in taking care of the baby. 5. client and family were encouraged to reduce the number of visitors in order for client to have enough sleep during the day.	07/12/21 7:30am	Goal fully met as client reported she can sleep for at least 6 hours within 24 hours.	**JAB**

PUEPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
08/12/21 7:30am	Altered bowel movement (constipation) related to hormonal changes	Client will be able to empty her bowel once daily within 24 hours as evidenced by client verbalizing that she is able to empty her bowel once daily.	1 Reassure client of hormonal changes to allay anxiety. 2. Explain the physiology of constipation to the client. 3. Encourage client on intake of fruits, roughages and vegetables. 4. Encourage client on mild exercises like walking. 5. Educate client on the intake of more fluids	1. Client was reassured on hormonal changes to allay fear. 2. The physiology of constipation was explained to client that it is caused by high progesterone levels during pregnancy and interruption in dietary. 3. Client was encouraged on the intake of fruits and vegetables to prevent constipation. 4. Client was encouraged on the need to exercise. 5. Client was educated on the intake of more fluids.	09/12/21 7:30am	Goal fully achieved as client said she was able to empty the bowel once daily.	**JAB**

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
09/12/21 8:40am	Breast engorgement related to hormonal activities in breast	Client' engorged breast will subside within 48 hours as evidence by 1.Client verbalizing that she is relieved of breast engorgement.	1. Reassure client her breast engorgement will subside. 2. Demonstrate to client on correct attachment of the baby to the breast. 3.Encourage client on gentle manual expression of breast milk and store it neatly 4.Encourage her to continue breast feeding the baby. 5. Encourage client to apply warm and cold compress on both breasts.	1. Client was reassured that it is temporal. 2. A demonstration was done how to properly fix baby to breast and stored. 3. Client was encouraged on gentle manual expression of breast milk 4. Client was encouraged to continue breast feeding the baby on demand and frequently. 5.Client was encouraged to apply warm and cold compress on both breast.	11/12/21 8:40am	Goal met at client reported that her breast engorgement subsides.	JAB

TERMINATION OF CARE

Explanation was given to Madam Hannah on the need to be handed over to the public health nurse in-charge for continuity of care. Explanation was made to her that our programme was ending so soon but client was reassured of midwife in-charge's competency. Client was accompanied to her house and a seat was offered. Client and her husband were thanked for their cooperation and information provided. They were reminded to register the baby at birth and death registry and also to complete baby's immunization scheduled and permission was sought to leave.

SUMMARY AND CONCLUSION

The Family Centered Maternity Care Study was conducted on Madam Hannah Boaa 24-year-old gravida 2 para 1. Care was given during antenatal and her entire family through pregnancy, labour and puerperium and she went through these processes safely without any complications.

Madam Hannah became a regular attendant at Agyei-Mensah Memorial Maternity Home on 25th May,2021. My first contact with client was on 15th November, 2021 with a gestational age of 37weeks. She was managed through pregnancy, labour and puerperium safely through which all minor disorders experienced were managed using the nursing care plan. She had a spontaneous vaginal delivery to a live male baby on 4th December, 2021 and discharged the next day. Client and family were visited for the first seven days after delivery.

She visited the child welfare clinic on her six weeks postnatal. Madam Hannah and her baby were in a healthy condition and they were handed over to the Public health -In-Charge of CWC for continuity of care.

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

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

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APPENDIX I : ANTENATAL RECORD BOOK

Date	Weight (kg)	Blood pressure (mmHg)	Urine Protein Sugar	Gestational age	Fund-al height (cm)	Presenta -tion	Descent	Foetal heart rate	Complains	Treatment	Name and signature
25/05/21	73	100/60	Negative	13^{+3}	-	-	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate,	VERA
22/06/21	74	100/60	Trace /Negative	17^{+3}	19	Cephalic	-	-	Chills and cough	Tablet (Multivite, folic acid, ferrous sulphate)	BELINDA
21/07/21	69.9	90/60	Negative	21^{+3}	22	Cephalic	-	-	No complain	Tablet (Multivite, folic acid, ferrous sulphate, sulphadoxine Pyrimethamine)	VERA
23/08/21	69.5	110/65	Trace/Negative	35^{+1}	33	Cephalic	-	130 beat per minute	No complain	Tablet (Multivite, folic acid, ferrous sulphate, sulphadoxine pyremethamine)	BELINDA
21/10/21	70	90/60	Trace/Negative	34^{+5}	33	Cephalic	-	138 beat per minute	No complain	Tablet (Multivite, folic acid, ferrous sulphate, Sulphadoxine Pyrimethamine)	BELINDA

15/11/21	76	100/60	Negative	37^{+4}	36	Cephalic	$4/5^{th}$	138 beat per minute	L.A,P and general discomforts	Tablet (Multivite, folic acid, ferrous sulphate)	J.A.B
23/11/21	55	105/60	Trace/Negative	38	36	Cephalic	$4/5^{th}$	139 beat per minute	L.A.P	Tablet (Multivite, folic acid ferrous sulphate.	J.A.B
30/11/21	76	100/60	Negative	38^{+5}	37	Cephalic	$4/5^{th}$	144 per minute	No complain	Tablet (Multivite, folic acid ferrous sulphate.	J.A.B

TABLE 2: ANTENATAL CHART

ITN Given – 14/08/2021

<table>
<tr><td rowspan="3">TETANUS IMMUNIZATION</td><td colspan="2">PREVIOUS TT</td><td colspan="2">TD 1 and TD 2</td><td colspan="2">Yes</td></tr>
<tr><td colspan="2" rowspan="2">CURRENT TT 2nd Dose</td><td colspan="2">Date 02/08/21</td><td colspan="2">Date</td></tr>
<tr><td colspan="2">Date 10/11/21</td><td colspan="2"></td></tr>
<tr><td rowspan="2">INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria</td><td rowspan="2">1ST dose SP*
3 tabs
(Directly Observed Therapy) 21/07/2021</td><td>Gestation age
In weeks</td><td rowspan="2">2nd dose (1 month after 1st dose
(Directly Observed Therapy)
23/08/2021</td><td>Gestation age
In weeks</td><td rowspan="2">3rd dose (1 month after 2nd dose
(Directly Observed Therapy)
21/10/21</td><td>Gestational age in weeks</td></tr>
<tr><td>21^{+3}weeks</td><td>23^{+1} week</td><td>34^{+5}weeks</td></tr>
<tr><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr>
</table>

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

APPENDIX II : COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUE	FINDING	REMARKS
25/05/2021	Urine	Sugar	Negative	Negative	Normal
		protein	Negative	Trace	Normal
	Blood	Haemoglobin level	11.4g/dl-16g/dl	8.5g/dl	Normal
		Sickling	Negative	Negative	Normal
		Grouping	A, B, AB, O	O	Normal
		Rhesus factor	Positive/negative	Positive	Normal
		HIV/AIDS	Negative	Negative	Normal
		Hepatitis	Negative	Negative	Normal
		VDRL	Negative	Non-reactive	Normal
		G6PD	Normal	Normal	Normal
22/06/2021	Urine	Sugar	Negative	Negative	Normal
		protein	Negative	Trace	Not Normal

21/07/2021	Urine	Sugar protein	Negative Negative	Negative Negative	Normal Normal
23/08/2021	Urine	Sugar protein	Negative Negative	Negative Trace	Normal Not Normal
21/10/2021	Urine	Sugar protein	Negative Negative	Negative Trace	Normal Not Normal
15/11/2021	Urine	Sugar protein	Negative Negative	Negative Trace	Normal Not Normal
23/11/2021	Urine	Sugar protein	Negative Negative	Negative Trace	Normal Not Normal
30/11/2021	Urine	Sugar Protein	Negative Negative	Negative Trace	Normal Not Normal

APPENDIX III: PHARMACOLOGY OF DRUG(MOTHER)

NAME OF DRUG	CLASSIFICATION	ROUTE	DOSAGE	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet folic acid	Vitamin preparation	Oral	5mg daily for 30days	Maturation of red blood cells	Nausea and vomiting	None
Tablet Multivitamin	Vitamin preparation	Oral	200mg daily for 30days	Increased appetite	Gastrointestinal irritation	None
Tablet ferrous sulphate	Iron preparation	Oral	200mg daily for 30days	Formation of red blood cells	Abdominal discomfort, diarrhoea dark stool	None
Tablet Sulphadoxine pyrimethamine	Anti-malaria and prophylaxis	Orally	3 tablet start from 16weeks intervals/quickening and the rest are taken in 4 weeks interval and after 36 weeks	Prevent malaria in pregnancy	Itching, vomiting, nausea	None
Tetanus toxoid injection	Anti-tetanus	Subcutaneous	0.5miligram	Prevention of tetanus	Slight fever and chills	None
Oxytocin	Oxytocic drug	Intramuscular	10units	Increase contractions	Hypotension and hyper stimulation	None
Vitamin A	Group A vitamin supplement	Oral	200000unit once daily	Growth development, prevent infection and blindness	Vomiting	None
Tablet paracetamol	Analgesic	Oral	500mg	Relieve pain	Liver damage with prolong use	None

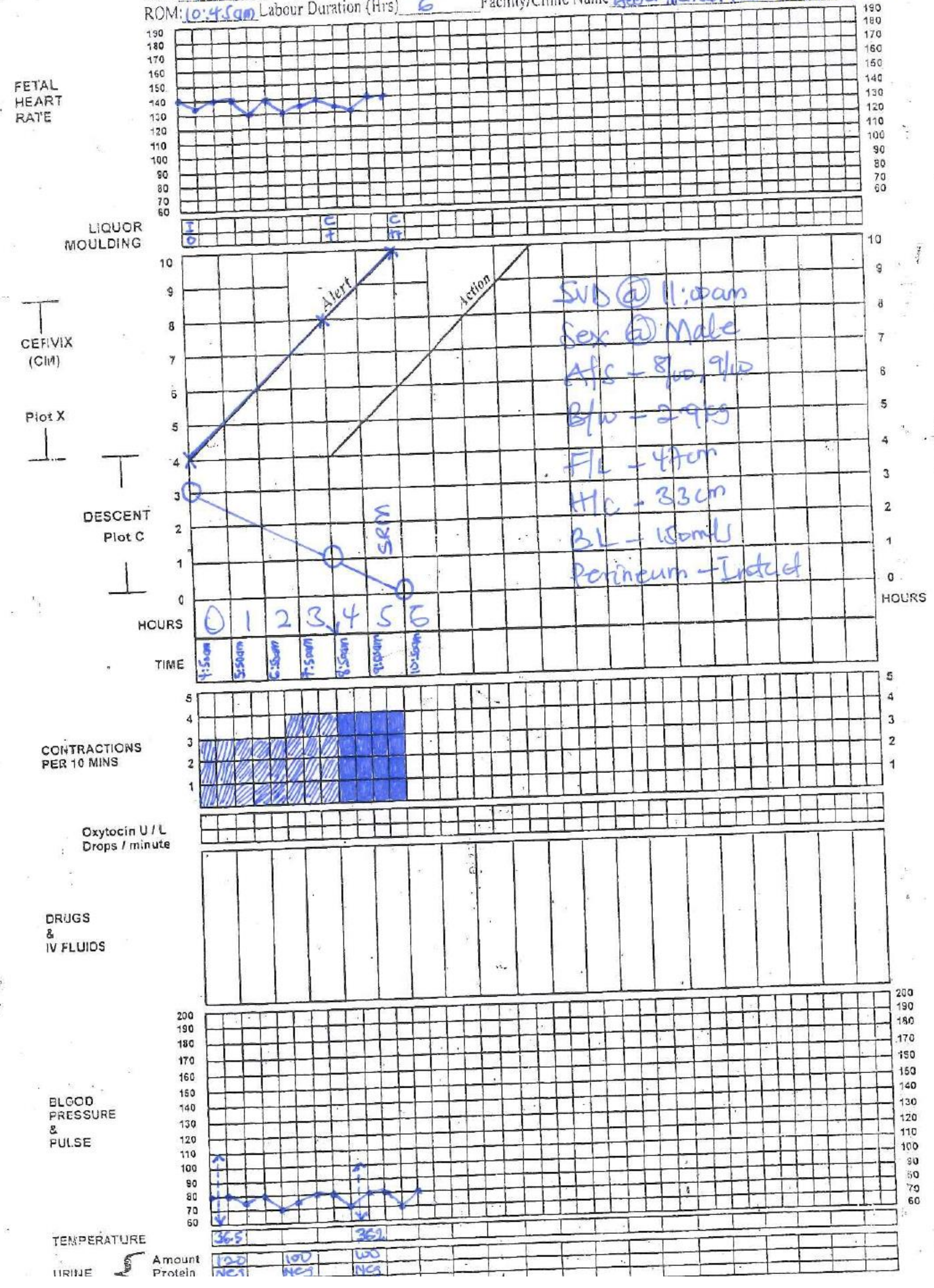
APPENDIX IV : PHARMACOLOGICAL DRUGS USED (BABY)

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

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

WHO Modified Partograph

Registration No.: 672/21 Name(Last, First) Boaa Hannah Age: 24yrs
Date: 4/12/21 Parity/Gravida 1, 2 LMP 19/03/21 EDD 27/11/21 Gestation(wks) 39wks
ROM: 10:45am Labour Duration (Hrs) 6 Facility/Clinic Name Amei-Mensah Memorial Mat. Home



LABOR NOTES

client G2P1 with 39weeks gestation reported to the facility at 4:40am with complains of Lower Abdominal Pains. On examination, SFH - 36cm, Pres - cephalic, Descent - 3/5th, FHR - 140bpm. V/E done at 4cm os dilated with vagina warm and moist and membranes intact. All findings communicated to client. Client delivered an alive male infant at 11:00am with APGAR Score of 8/10, 9/10 respectively. IM oxytocin administered and placenta and its membranes delivered successfully by controlled cord traction - client and baby are doing well and being transferred to the lying in ward. client made comfortable in bed.

Please circle or write responses.

DELIVERY

DATE: 4/12/21 TIME: 11:00am METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 11:01am Type/Dose 10 units of oxytocin

PLACENTA: TIME: 11:05am (Complete) / Incomplete

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

BABY

Weight: 2.9kg.

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

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

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

	Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladder
FOURTH STAGE MONITORING	Every 15 minutes first 2 hours	11:10am	100/60	78bpm	17cm	150mls	Emptied
		11:25am	105/70	80 bpm	Contracted	Small	
		11:40am	105/60	85 bpm	Contracted	Small	Emptied
		11:55am	105/65	81 bpm	Contracted	Small	
		12:10pm	110/70	79 bpm	Contracted	Small	Emptied
		12:25pm	105/70	82 bpm	Contracted	Small	
		12:40pm	105/60	85bpm	Contracted	Small	Emptied
		12:55pm	110/65	86bpm	Contracted	Small	
	Every 30 minutes For 1 hour	1:25pm	105/67	88bpm	Contracted	Small	Emptied
		1:55pm	105/60	79bpm	Contracted	Small	

Birth Attendant ADJEI BEMEWAA JOANA | ELORM BELINDA Date 04/12/21

MATERNITY CHART

NAME: Hannah Boag

AGE: 24yrs WARD: Lying In

IP NO.: 672/21 BED NO.: 7

Date	4/12/21	5/12/21	6/12/21	7/12/21	8/12/21	9/12/21	10/12/21	11/12/21	14/12/21
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour Am	11:00	7:30	7:00	7:30	7:00	8:00	8:30	7:45	9:40
Hour Pm	-	4:00	4:00	4:30	4:20				
Pulse	80	81 / 79	88 / 90	78 / 74	76 / 80	78	76	78	80
Resp.	20	19 / 18	19 / 18	20 / 19	21 / 19	21	20	21	18
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
B. P. AM	110/60	110/65	100/60	110/70	100/60	110/70	110/65	110/70	100/65
B. P. PM		100/60	110/60	100/75	110/65				

Temperature

C	F
41°C 41.1	17cm 106
40.5°C 40.5	16cm 105
40°C 40.0	15cm 104
40°C 39.4	14cm 103
39.5°C 38.8	13cm 102
38.5°C 38.3	12cm 101
38°C 37.7	11cm 100
38°C 37.2	10cm 99
37.5°C 36.6	9cm 98
37°C 36.1	8cm 97
36.5°C 35.5	7cm 96
36°C 35	6cm 95

KEY

Blue → TEMPERATURE

Red → SYMPHYSIS – FUNDAL HEIGHT

SCALE → 1cm : 1unit

NEW BORN EXAMINATION FORM

Name: Baby Kwame Boaa Date of Assessment: 04/12/21 Time: 11'50am
Date of Birth: 04/12/21 Time of Birth: 11:00 am Sex: [x] M [ ] F Age at time of Assessment (days/hrs) 1hr
Astational Age [ ] 39wks [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section
APGAR: 1min 8/10 5min 9/10 Birth Weight: [ ] 2.9kg [ ] Length: 47 cm Head Circumference: 33 cm
Temperature at time of Assessment: 36.9 °C Urine passed: Yes No Meconium passed: Yes No
Name of Assessor (Midwife/Doctor): Adjei Benewaa Joana (Student Midwife)

1. Respiration
Rate 42 cpm
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [x] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

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

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

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

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

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

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

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

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

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

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

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

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

15. Neck
- [x] Normal
- [ ] Swelling
- [ ] Webbed
- [ ] Other: ________

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

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

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

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

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

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

22. Limbs
- [x] Normal
- [ ] Abnormal ________

23. Genitalia
Male Genitalia
- [x] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other: ________

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

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

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) ________

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

NEW BORN EXAMINATION FORM

Name: Baby Kwame Boaq Date of Assessment: 05/12/21 Time: 11:50 am

Date of Birth: 04/12/21 Time of Birth: 11:00 am Sex: [x] M [ ] F Age at time of Assessment (days/hrs) 1 day

Astational Age [ ] 39wks [ ] Mode of Delivery: [x] Vaginal Assisted Vaginal C-Section

APGAR: 1min 8/10 5min 9/10 Birth Weight: [ ] 2.9kg [ ] Length: 47 cm Head Circumference: 33 cm

Temperature at time of Assessment: 37.1 °C Urine passed: Yes No Meconium passed: Yes No

Name of Assessor (Midwife/Doctor): Adjei Benewaa Joana (student Midwife)

1. Respiration
Rate 44 cpm
- [ ] Rate < 30 b/m *
- [ ] Rate < 60 b/m *
- [x] 30-60 b/m
- [ ] Retractions *
- [ ] Grunting *
- [ ] Stridor *

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

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

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

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

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

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

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

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

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

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

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

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

15. Neck
- [x] Normal
- [ ] Swelling
- [ ] Webbed
- [ ] Other: ____

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

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

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

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

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

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

22. Limbs
- [x] Normal
- [ ] Abnormal ____

23. Genitalia
Male Genitalia
- [x] Normal
- [ ] Undescended testes
- [ ] Abnormal meatus
- [ ] Hernia
- [ ] Other: ____

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

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

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known)____

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

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

TEMPERATURE CHART

NAME: Baby Kwame Boag

AGE: New born WARD: Lying In

IP NO.: 672/21 BED NO.: –

Date	4/12/21	5/12/21	6/12/21	7/12/21	8/12/21	9/12/21	10/12/21	11/12/21	14/12/21					
Days in Hospital	D0	D1	D2	D3	D4	D5	D6	D7	D8					
Days P. O.														
Hour Am	11:00	7:30	7:00	7:30	7:00	8:00	8:30	7:45	9:40					
Hour Pm		4:00	4:00	4:30	4:20									
Pulse	134	134, 136	135, 134	130, 136	131, 132	126	129	132	128					
Resp.	42	44, 45	45, 44	40, 43	39, 48	43	42	44	40					
B.M.	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed					
Urine	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed					
B. P. AM/PM														

Temperature.

C | F

Printed scale: 41.1° 106° / 40.5° 105° / 40.0° 104° / 39.4° 103° / 38.8° 102° / 38.3° 101° / 37.7° 100° / 37.2° 99° / 36.6° 98° / 36.1° 97° / 35.5° 96° / 35° 95°

Handwritten scale (°C): 40.5 / 40 / 39.5 / 39 / 38.5 / 38 / 37.5 / 37.0 / 36.5 / 36.0 / 35.5 / 35.0

Handwritten scale (kg): 3.2kg / 3.1kg / 3.0kg / 2.9kg / 2.8kg / 2.7kg / 2.6kg / 2.5kg / 2.4kg / 2.3kg / 2.2kg / 2.1kg

KEY
→ TEMPERATURE
→ BIRTH WEIGHT
Scale → 1cm : 1unit

NEW BORN CHART

Name: Baby Kwame Boaa .... No: .... Birth Weight: 2·9kg

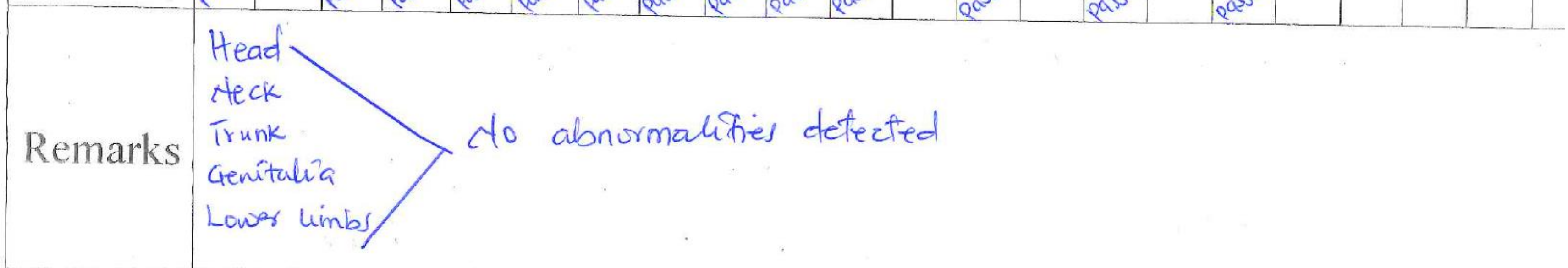
Sex: Male .... Mother's No: 672/21 .... Length: 47cm

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

Date of Birth: 04/12/21 .... Time: 11:00am .... Date of Discharge: 05/12/21

Date	04/12/21		05/12/21		06/12/21		07/12/21		08/12/21		09/12/21		10/12/21		11/12/21		14/12/21					
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	2·9kg		2·9kg		2·8kg		2·7kg		2·7kg		2·8kg		2·9kg		3·0kg		3·1kg					
	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	P
Temperature	36·9°c		37·1°c	36·7°c	37·0°c	36·6°c	37·0°c	36·8°c	36·7°c	36·6°c	37·0°c		36·5°c		36·7°c		36·9°c					
Stools	passed		passed	passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed					
Urine	passed		passed	passed	passed	passed	passed	passed	passed	passed	passed		passed		passed		passed					

Remarks



SIGNATORIES

THE STUDENT

NAME: MISS. ADJEI BENEWAA JOANA

SIGNATURE: ....

DATE: 10TH OCTOBER 2022

THE MIDWIFE IN CHARGE

NAME: MRS. ELIZABETH OWUSU

SIGNATURE .... (for)

DATE: 11/10/22

THE SUPERVISOR

NAME: MS. MONICA BOAKYE

SIGNATURE: ....

DATE: 11/10/2022

THE PRINCIPAL

NAME: MONICA NKRUMAH

SIGNATURE: .... (for)

DATE: 11/10/22

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