HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE, BEREKUM

A CLIENT/ FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM KONADU DOREEN

BY

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SUBMITTED TO THE NURSING AND MIDWIFERY COUNCIL OF GHANA IN PARTIAL FULFILMENT TOWARDS THE AWARD OF LINCENSE TO PRACTICE AS A PROFESSIONAL REGISTERED MIWIFE.

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PREFACE

Client and Family centered maternity care study is a systematic, comprehensive and holistic approach used in rendering obstetric care to the expectant mother and her family as a whole throughout pregnancy, labour and puerperium. The care involves data collection, nursing diagnosis, assessment, identification of problems, planning; implementation and evaluation of the data that would help solve the individual's problems. The care also focuses on the mother's physical, emotional, spiritual, psychological and social needs to help attain standard of care.

The family centered maternity care study also gives the student midwife an opportunity to use her knowledge and skills acquired both practically and theoretically during her period of training to care for a pregnant woman throughout pregnancy, labour and puerperium. In this a pregnant woman of G3P2 was used in the study.

The use of partograph and nursing process will help in the management of first stage of labour and to diagnose any complication during pregnancy. The nursing process provide framework for solving problems and making decisions in the management of the client and family in a systematic manner. The study also enables student midwife to educate the client and family and also promote cordial relationship between the student midwife, the mother and her family.

Furthermore, the study helps the student midwife to put into practice the concept of safe motherhood initiative which has being adapted to render quality maternity care through antenatal, labour and puerperium which will eventually reduce maternal and neonatal mortality. The family centered maternity care study is an academic exercise required by the Nursing and Midwifery Council of Ghana so as to enable the student midwife to practice after completion of her training.

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INTRODUCTION

The Client and Family Centered Maternity care study was on Madam Doreen Konadu, a 27years old, Gravida 3 Para 2 all alive and her family who live at Mpuasu. Client was first met on 25th October, 2021 at 37weeks of gestation and in good health. She went through pregnancy, labour and puerperium successfully and delivered a healthy baby boy on the 8th November, 2021. Mother together with her baby was discharged on the 9th November, 2021. To maintain confidentiality, she will be called Madam Doreen throughout the study. The client was visited at home on several occasions and the entire family as well were included in the care. Her condition and that of the baby were stable and good at the end of the study and both mother and baby were handed over to the midwife in-charge for continuity of care. This study is made up of four chapters namely, chapter one, chapter two, chapter three and chapter four.

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

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

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

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

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

LITERITURE REVIEW
PREGNANCY

Tiran (2009) defined pregnancy as a period from conception to delivery of the feotus. Normal duration is 280 days (40 weeks or 9 months and 7 days), counted from conception to delivery. Henderson (2009) stated that, pregnancy may be suspected by the woman based on the knowledge on her menstrual cycle, sexual activity and the signs and symptoms of pregnancy. They are; amenorrhea, nausea and vomiting, breast changes, enlargement of the uterus, frequent micturition, skin changes and quickening. These signs and symptoms of pregnancy may be considered as presumptive, probable, and positive. They become obvious to the woman as her pregnancy advances. Women may confirm their pregnancy using home pregnancy test.

Henderson (2009) further stated that, confirmation of pregnancy may also be sought form the midwife or doctor. This is established by a detail history and relevant clinic examination based on the signs and symptoms of pregnancy. King et al, (2014) also stated that, the prenatal period is divided into trimesters, first trimester is considered to be weeks 1 to 12 (12 weeks) because organogenesis is complete at the end of twelve weeks and the end of spontaneous abortion is significantly reduced at time. Historically, the second trimester was considered to be weeks 13 to 28 because prior to the introduction of modern neonatal intensive care technique, 28 weeks was limit of viability. The third trimester extends from weeks 28 to 40. The term post - date or post term is typically used to describe a pregnancy beyond forty weeks (40).

According to King et al, (2014), pregnancy is a 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 lasts approximately Two Hundred and Sixty, Six days (266 days) or

thirty, Eight weeks (38 weeks) from ovulation. King et al, (2014) stated that, the prenatal period covers the time from the first day of the last normal menstrual period to the start of labour, which marks the beginning of the intrapartum period.

Konar (2013) also added 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.

Konar (2013) further stated that, there is enormous growth of the fetus during pregnancy. The uterus which in non – pregnant state weighs about 60g with a cavity of 5 – 10ml and measures about 7.5cm in length, at term, weighs 900 – 1000 g and measures 35cm in length. The capacity is increased by 500 – 10000 times and changes occur in all parts of the uterus. There is increase growth and enlargement of the body of the uterus. Not only individual muscle fibers increase in length and breadth but there is also limited addition of new muscle fibers. These occur under the influence of the hormones; oestrogen and progesterone limited to the half year of pregnancy, pronounced up to twelve weeks (12). Three (3) distinct layer of muscle fibers are evidenced, outer longitudinal; inner – circular and intermediate. Normal anteverted position is exaggerated up to eight (8weeks). Thus, the enlarged uterus may lie on the bladder rendering it incapable of filling, clinically evident by frequent micturition. Afterwards, becomes erect; the long axis of the uterus conforms more of less to the axis of the inlet.

Fraser & Cooper (2009) also added that uterine blood flow in pregnancy supplies the myometrium, endometrium and placenta, with the latter receiving nearly 90% of the total uterine blood flow near term.

Konar (2013) stated that, there is marked congestion with hypertrophy of the muscles and 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.

According to Konar (2013), 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 gastric acid content into esophagus may produce chemical esophagitis and heart burn. There is diminished gastric secretion and delay emptying time of stomach. Risk of peptic ulcer is reduced. A tonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

According to Ghana Health Service (2008), the number of times a client needs to be seen during pregnancy may vary. For the uncomplicated pregnancy, it is recommended that at least four ANC visits should be made according to the following schedule.

- First Visit: From onset of pregnancy up to sixteen weeks (16) gestation.
- Second visit: From the 24^{th} to 28^{th} week of pregnancy.
- Third Visit: at 32^{nd} week of pregnancy.
- Fourth Visit: at 36^{th} week of pregnancy.

LABOUR

Henderson (2009) stated that normal labour naturally follows a sequential pattern that involves painful regular uterine contractions stimulating progressive effacement and dilatation of the cervix and decent of the fetus through the pelvis, culminating in the spontaneous vaginal birth of the baby, followed by the expulsion of the placenta and membranes. King (2014) also stated that, labour is the process by which childbirth occurs, requiring uterine contractions of sufficient frequency, duration and intensity to cause demonstrable effacement and dilatation of cervix. Marshall & Rayno (2014) also added that, 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 the baby and can influence the likelihood and / or experience of future pregnancies.

Marshall & Raynor (2014) again stated that, human pregnancy is considered to last approximately 40 weeks, with labour usually occurring between 17 and 42 weeks gestation. Complex physiology 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.

Marshall & Raynor (2014) further stated that, traditionally, three stages of labour are described, the first, second and third stage, but this is a rather pedantic view, as labour is obviously a continuous process. It has also been acknowledged that, there are more than three stages of labour, namely, the latent, active and transitional phases and these not only encompass specific physical changes but should also account for the emotional effect observed in women during this time.

Konar (2013) also stated that, conventionally, events of labour are divided into three stages.

- First stage starts from the onset of true labour pains and ends with full dilatation of the cervix. It is in other words, “Cervical stage” of labour. Its average duration is twelve hours (12) in primigravida and six hours (6) in multipara.
- Second stage starts from the full dilation 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 phases, thus the propulsive phase starts from full dilatation up to the descent of the presenting part of 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 (afterbirths). It average duration is about fifteen minutes (15) in both primigravida and multipara. The duration is 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 birth. During this period, general condition of the client and the behavior of the uterus are to be carefully monitored.

King et al, (2014) noted that the term fourth stage of labour refers to the first postpartum hour following placental expulsion.

According to Marshall & Raynor (2014), the onset of labour is a process, not an event; therefore, it is very difficult to identify exactly when the painless (Sometimes painful) contractions of pre labour develop into progressive rhythmic contractions of established labour. Diagnosing the onset of labour is extremely important, since it is on the basis of

this finding that decision are made that will affect the intrapartum care and support subsequently provided.

King et al, (2014) also stated that, the onset of labour is classically defined as the occurrence of regular painful contraction that promotes dilation of the cervix. Contractions that occur at regular intervals with increasing frequency, duration and intensity are the hallmark of labour. The onset of spontaneous labour cannot be reliably predicted, although many pregnant women experience premonitory signs or symptoms of impending labour. Common signs and symptoms suggestive of physiologic progress towards labour include descent of the fetus, cervical changes, increase in uncoordinated uterine contractions, rupture of membranes, bloody show or increased mucus discharge from the vagina, maternal perception of increased energy, gastrointestinal distress.

King et al, (2014) further stated that, physiologic adaptations during labour are required to support the unique demands imposed on both the woman giving birth and her fetus. Traditionally, the processes involved in labour and birth have been conceptualized as those that affect the power (uterus), the passenger (fetus) and the passage (pelvis).

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- Put the care plan into practice and
- Evaluate the care given to measure its effectiveness

Henderson (2009) also stated that under emotional and psychological care, it is important for the midwife to have a good understanding of women's feelings in labour. Attitudes and reactions to childbirth vary considerably and are influenced by differing social, cultural and religious factors. Many women anticipate labour with mixed feelings of fear and excitement.

Henderson (2009) further stated that, throughout labour, there should be a free flow of information between the women and her partner and the midwife, particularly in relation to examinations and their findings. Being fully informed and involved in decision making helps the women to retain a sense of autonomy and control. The midwife should be aware that not all individuals may feel sufficiently secure or able to express fear or anxiety during labour.

Konar (2013) further stated that under bladder care, client is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection.

If the women cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the client fails to pass urine especially in late first stage, catheterization is to be done with strict septic precautions.

Marshall & Raynor (2014) also stated the following under bath or shower. Immersion in a warm bath or birthing pool can be an effective form of a pain relief for labouring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or fetus. The midwife should invite the woman who is mobile to have a bath or shower whenever she wishes during labour.

According to Konar (2013), under rest and ambulation, if the membranes are intact, the client is allowed to walk about. This attitude prevents vena cava compression and encourages descent of the head. Ambulation can reduce the duration of labour, need of analgesia and improves maternal comfort if, however, labour is monitored electronically or analgesic drug (epidural analgesia) is given, she should be in bed. According to Konar (2013), assessment of progress of labour and partograph recording are also done. Partograph are tools that allow labour progress to be graphically recorded and visually assessed. They aid in the early detection of abnormal labour progress and are credited by some for decreasing rated of

prolonged labour, oxytocin use, caesarean section and intrapartum morbidity/mortality as compared to usual care. Use of partograph is initiated during presumed active labour.

According to Marshall & Raynor (2014), active management of the third stage of labour (AMTSL): An active management policy usually includes the routine prophylactic administration of a uterotonic agent, either intravenously, intramuscularly or (Occasionally) orally, as a precautionary measure aimed at reducing the risk of post-partum haemorrhage. It is applied regardless of the assessed obstetric risk status of the woman, and is usually undertaken in conjunction with clamping of the umbilical cord shortly after birth for the birth and delivery of the placenta by the use of controlled cord traction.

PUERPERIUM

Tiran (2008) stated that puerperium is the period following childbirth during which the uterus and other organs and structures are returning to their non-pregnant state, a period of 6-8 weeks. According to 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. Konar (2013) also stated that puerperium is the period following child birth in which the bodies tissues, especially the pelvic organs revert back approximately to the pre – pregnant state both anatomically and physiologically.

During puerperium the following physiological changes take place in all women as the body returns to its pre-pregnant state:

- Involution of the uterus and other soft parts of the genital tract.
- Commencement of lactation

- Physiological changes in other systems of the body. It is important that the midwife is familiar with these to ensure that appropriate care and advice are given.

According to Konar (2013), involution is the process whereby the genital organs revert back approximately to the state as they were before pregnancy. The woman is termed as puerperal.

Furthermore, Konar (2013) stated that puerperium begins as soon as the placenta is expelled and lasts for approximately 6 weeks when the uterus becomes regressed almost to the non-pregnant size. The period is arbitrarily divided into immediate-- within 24 hours; early – up to 7 days and remote – up to 6 weeks.

Henderson (2009) stated that the secretion of prolactin from the anterior pituitary gland initiates lactation. Once lactation commences, it is maintained by the baby suckling. This provides the natural stimulus for the release of prolactin.

Again, Konar (2013) stated that lochia is the vaginal discharge for the first fortnight during puerperium. The discharge originates from the uterine body, cervix and vagina. Depending upon the variation of the colour of the discharge, it is named as:

- Lochia rubra: red, 1-4 days
- Lochia serosa: 5-9 days, the colour is yellowish or pink or pale brownish.
- Lochia Alba: 10-15 days, pale white.

Konar (2013) added that, the average amount of discharge for the first 5-6 days is estimated to be 250mls. Normal duration may extend up to 3 weeks. Henderson (2009) stated that 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.

Fraser & Cooper (2009) also stated that, regardless of whether women are breastfeeding, they may experience tightening and enlargement of their breast towards the 3rd or 4th day. Hormonal influences, encourage the breast to produce milk for women who are breastfeeding, the general advice is to feed the baby and avoid excessive handling of the breast. Simple analgesics may be required to reduce the discomfort.

Henderson (2009) further stated that, the falling levels of progesterone affect the alimentary tract. The smooth muscle tone gradually improves throughout the body and symptoms of heartburn the women may have experienced should resolve. Constipation may however remain a common problem during the postnatal period. Fraser Cooper further stated that 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 pain is by an appropriate analgesic.

WHY CLIENT WAS CHOOSEN

On 25rd, October 2021 which was Monday at 10:40am Madam Doreen was met at Adamsu Health Center, Adamsu, during ANC visit. Client was moody and sitting at a corner so client was approached and asked the reason, she then complained of severe waist pains. Client was then taken to the palpation room and sacral massage was performed, and later she verbalized that, she is now relieved of the waist pain. After going through her antenatal card, her gestational age was 37weeks. She was fit to be used as my client for the family centered care study.

All her laboratory results were good and expected date of delivery was (EDD) 9/11/2021.

Introduction was made and had interest in educating the physiology of waist pains and other physiological changes in pregnancy to the client.

Client was informed about my interest to take her as my client and she agreed, she then gave me her number and told me where she lives. The midwife in- charge was also informed and she gave me the go ahead. This made me chose her as my client for the study. Client says at Mpuasu.

ONE CHAPTER

CLIENTS PARTICULARS

1.0 INTRODUCTION

This chapter deals with assessment of the client. It gives information about Madam Doreen, the client used for the study, her social history, daily habits, surgical, menstrual, obstetric and family histories. Information was acquired through observation, interview and antenatal care.

1.1 PERSONAL AND SOCIAL HISTORY

Madam Doreen is 27years of age and stays at Mpuasu in the Bono region with her family. She speaks Bono and Twi. She is fair in complexion and is 163.4cm tall and weighs 59kg at booking. Her level of education ended up to junior high school. Client is a farmer and a trader. She is married to Mr Gideon Afful, who is a poultry farmer. They have been married for (6) six years now. Mr Gideon Afful is 27years of age who also lives in Mpuasu. He speaks English and Twi. He comes from Mpuasu in the Bono region.

Madam Doreen intention is to deliver at Adamsu Health Center at Adamsu; She is a Christian and attends church every Sunday with her family at the Presbyterian church of Ghana. Client has two children, (one boy and one girl). Her first son is 9years old and the second daughter is 4years old. Madam Doreen's next of kin is her sister (Madam Esther konadu).Client does not smoke neither does not take alcohol.

1.2 MEDICAL HISTORY

According to client, she has never been admitted to the hospital before she mentioned that she sometimes experience minor illness which is treated on Out-Patient Department basis(OPD). Client said she usually experiences malaria but does not have any condition like hypertension, sickle cell disease, diabetes, epilepsy, HIV infection, asthma, respiratory

disease TB, mental illness and among others. She has no known allergies to food and drugs. She is also not on any medication for any chronic illness.

1.3 SURGICAL HISTORY

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

1.4 FAMILY HISTORY

Opanin Yaw Asare and Madam Ama Kyeremaa are the parents of Madam Doreen. She is the first born among two children of her parents. According to her, her parents died two years ago .Madam Doreen said there are no known hereditary conditions such as sickle cell disease, hypertension, mental disorder, epilepsy, diabetes and asthma in her family. She further stated that there is no history of multiple pregnancies in her family. According to her death in her family occurs naturally.

1.5 MENSTRUAL HISTORY

According to client, she has a twenty-eight (28) days menstrual cycle and bleed for four days. She had her menarche at the age of fifteen (15) and since had a regular menstrual flow with no dysmenorrhea. She uses sanitary pad during her menstruation and she changes it at least twice a day.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Doreen wakes-up around 6am and goes to bed around 9pm. She washes her face and brushed her teeth with toothbrush and toothpaste. She then sweep her compound and bath her children. Client then takes her bath and prepares breakfast for the family. Before she goes to the farm. Madam Doreen closes from the farm around 3:00pm and goes back home and

prepare supper for her family around 4:30pm. She eats thrice daily and empties her bowel at least once a day, she neither smokes cigarette nor takes in alcoholic drinks

On Saturdays client cleans the house with the help of her family, her dirty clothes as well as that of her husband and children are washed and dried in the sun. Madam Doreen favourite food is fufu with groundnut soup. She enjoys conversing and use her leisure time mostly to sleep. On Sundays client goes to church with her family and closes around 12:00pm. Client goes to the market every Wednesday (which is a market day) to buy foodstuff in bulk and shops for the items that she would need in the upkeep of the house. She then comes home and prepares for her family.

1.7 PAST OBSTETRIC HISTORY

Pregnancy

Madam Doreen G3P2, all alive went through her pregnancies without any complications such as antepartum haemorrhage, severe anemia and gestational diabetes but sometimes suffers from minor disorders such as heartburns, abdominal pain and had term pregnancies. All her pregnancies were up to term. The interval between the first and second pregnancy was five years and the interval between the second pregnancy and the current pregnancy is four years. She has no history of abortion. She said she has had four doses of tetanus- Diphtheria injection during her first and second pregnancy and had all the doses of sulphadoxine pyrimethamine as prophylaxis against malaria. She was a regular attendant to antenatal care until she delivers.

Labour

She had spontaneous vaginal delivery not more than 18hours for the two children. She delivered all her two children at Adamsu Health Center, her second born weighed 3.0kg at birth but could not remember the first baby's weight. They all cried as soon as they were delivered. The third stage was actively and properly managed within five (5) to ten (10) minutes without any complications, she further mentioned that she had no history of retained placenta and the perineum was always intact. In the fourth stage, the condition of the mother and the babies were good. She has no postpartum haemorrhage according to her.

Puerperium

Madam Doreen puerperal period according to her was normal. She had no puerperal psychosis, sub-involution and she visited the postnatal clinic as scheduled. She and her babies were healthy throughout. She practiced exclusive breastfeeding for six (6) months and combine supplementary feed like corn dough, porridge and cerelac while she continues with the breastfeeding till her children were two years old. According to Madam Doreen, all her children received the immunization against childhood preventable diseases. She opted for family planning method which was injection Depo Provera and she received support from her husband and her mother during her previous deliveries. According to her, her children have been healthy since birth.

1.8 PRESENT OBSTETRIC HISTORY

Madam Doreen G3P2AA visited the antenatal clinic on the 9th June, 2021. At Adamsu Health Center in Adamsu. According to her, last menstrual period was 1st February, 2021 and her expected date of delivery was 9th November, 2021. (According to scan). On Madam Doreen first antenatal clinic visit, her history was taken and recorded which included personal, family, medical, surgical and obstetrical histories. Laboratory investigations were also taken

and physical assessment was done and recorded. Results of investigations which were carried out are as fellows;

Hemoglobin Level - 10.2g/dl

Sickling Test - Negative

Blood group - O

Rhesus factor - Positive

G6PD - No defect

VDRL - Negative

HIV status - Not reactive

Urine R/E - No abnormalities detected

Stool R/E - No abnormalities detected

The following observation were made and recorded

Temperature - 36.7^{o}c

Pulse 84bpm

Respiration - 23cpm

Blood Pressure - 120/80mmHg

Hepatitis B status - Negative

Her measurements were taken as follows:

Weight - 59kg

Height - 163.4cm

Records on madam Doreen antenatal card indicated that she was examined from head to toe and no abnormalities were detected. On abdominal examination, no abnormalities were detected and symphysio-fundal height was palpable which measures 20cm and gestational age was 20weeks. She had no complaints, therefore she was served with the following routine drugs.

Tablet folic acid - 5mg (1 daily) for 30days

Tablet ferrous sulphate - 200mg (1 daily) for 30days

Tablet multivitamin - 200mg (1daily) for 30days.

She was scheduled for the next visit which she followed correctly and carried out all the laboratory investigation requested until she was met. She had attended ANC 4 times before we met. She had taken 3SP and the 4^{th} dose of TD.

CHAPTER TWO:

ANTENATAL CARE

2.0 INTRODUCTION

This chapter deals with the care that was given to client during her antenatal period. It include first contact with the client, home visits during antenatal period, subsequent visit to the hospitals and the care plans written to solve problems confronted by client.

2.1 FIRST CONTACT WITH CLIENT

Madam Doreen was met on the 20th October, 2021 at Adamsu Health Centre at Adamsu during the antenatal day when she was 37 weeks pregnant. It was her fifth visit to the hospital. Client was moody sitting at a corner so client was approached and asked the reason, she then complained of severe waist pains. Client was then taken to the palpation room and sacral massage was given she later verbalized that, she is now relieve of the waist pains. This woman was approachable and ready to share any information. Introduction was made as Augustina Danquah, a student midwife from holy family nursing and Midwifery Training College Berekum on a practical field for Family

Centred Maternity Care Study. She was afterwards sent to the vital signs table where her vitals was taken and recorded in the antenatal book. Her antenatal book was collected and found out that she was fit to be used as my client for the family centred Maternity care study. Madam Doreen was informed that, she would be monitored closely from pregnancy through labour to puerperium as she has been chosen for care study. Client humbly agreed. She was

thanked for her understanding and co-operation. She was also assured of confidentiality. The in-charge was also informed about the selection and she agreed to it. She was then taken through the general examination when it got to her turn with procedure explained. She was encouraged to asked questions. Below is the results recorded on first contact with client.

Temperature - 36.5^{o}c

Pulse - 92bpm

Respiration - 21cpm

Blood pressure - 100/60mmHg

Weight - 76kg

Height - 154cm

Urine for protein and sugar - Negative

Haemoglobin level - 11.4g/dl

Before the examination was carried out, client was informed and she gave her approval for the procedures to be carried out. She was reassured that all findings will be communicated to her and she was asked to empty her bladder and was assisted to lie on the bed. Soap and water were used in washing of the hands after which they were dried with a clean towel and privacy was ensured. Head to toe examination was performed thoroughly.

2.2 **PHYSICAL EXAMINATION**

Head and neck.

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

The face was inspected for acne, chloasma, edema and rashes but no abnormality was detected. The ears were inspected and there were no discharges. The eyes were inspected for jaundice of the sclera, pallor of the conjunctiva, alignment with the ears and discharges but nothing abnormal was detected. Also client lips were inspected for pallor, dryness, lesions, sores and mouth for tooth decay, loss of teeth and halitosis but no abnormality was detected. Madam Doreen's neck was also checked and palpated. Suitably there was no enlarged thyroid gland, lymph gland and no distended neck vein or lumps.

Breast examination

During the examination, both breast were exposed to check for size, shape, dimpling, nipple retraction, signs of pregnancy and condition of the skin. One breast was covered and she was asked to put hand of the part to be examined under her head. The breast was systematically palpated in a circular manner using the inner aspect of the fingers starting from the axillary tail of Spence. No abnormality was found. There were no masses, lumps, cracked or sore nipple and enlarge axillary lymph nodes. Client nipple was squeezed gently for fluid and cleans with swab. Accordingly, the fluid was examined and no abnormality was found. The same was done for the other breast and no abnormality was found. Client was also taught self-examination of the breast. The condition of the skin was also good. Client was assisted to redress and findings communicated to her. Client was thanked for her co-operation. Hands were washed and dried and findings recorded. She was educated on the need to wear well-fitting brassieres and how to perform self- breast examination.

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

Back

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

2.3 ABDOMINAL EXAMINATION AND PALPATION

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

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

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

Fundal palpation: Fundal palpation is carried out to find out the lie and presentation of the fetus. Facing Madam Constance, palms were rubbed together to provide warmth and to prevent inducing contractions. To determine what is found at the fundus of the client, the palm was placed on the abdomen below the xiphisternum and was gently moved downwards until the fundus was felt.

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

Pelvic palpation: Pelvic palpation is used to identify the presentation, which is the part of the foetus lying in the lower pole of the uterus, over the pelvic brim. This examination was done facing Madam Doreen's feet. She was asked to flex the knee slightly and helped to relax by guiding her to breathe out slowly. Both hands were used in the process. One hand is placed on the either side of the presentation and pressure is applied with the other hand. Accordingly, a hard mass was felt at the lower pole indicating the head of the fetus. The lie was longitudinal and presentation was cephalic.

Descent of the head: Location of the anterior shoulder was made and two fingers were placed on it. The symphysis pubis was located and the right ulna border was placed just

above the symphysis pubis and the anterior shoulder. Five fingers occupied the space indicating decent of 5/5.

Auscultation: On auscultation, the fetal stethoscope was warmed by rubbing in the palm and placed at the area where the foetal back was located to listen to the foetal heart rate. With one hand at the maternal radius to ensure that it is not the maternal pulse being listened to, the foetal heart rate was checked for one minute and recorded as 140beat per minute.

Vulva and perineum: Permission was sought to inspect the vulva and it was granted. A pillow was placed under her head and she was draped to provide privacy and modesty. Hands were washed with soap and clean running water and dried with clean towel. Sterile gloves were worn on both hands and the vulva and perineum were examined for abnormal discharges, rashes, genital wart, ulcers, scars and varicose vein. The labia majora was examined for same size and shape, redness, swelling and tenderness and nothing abnormal was detected. The client was asked to lie laterally and sit up before getting out of the couch. Madam Doreen was thanked for her cooperation and findings were communicated to her. All equipment's were decontaminated appropriately. The gloves were removed and discarded. Hands were washed with soap under running water and dried with clean towel and all findings recorded in her antennal record book. Client was asked of any complains and questions. Client complains of waist pain. She was educated that, the pain was due to the weight of the gravid uterus. Client was encouraged to have enough rest and sleep and also taught how to perform exercise in pregnancy such as pelvic rock which helps to relieve back and waist ache, head and shoulder lift which helps to strengthen abdominal muscles and kegel exercise which helps to strengthen the pelvic floor muscles that makes delivery easier. She was also encouraged to take her drugs as prescribed.

Health education was given on birth preparedness, labour and delivery. She was also informed on home visits which she agreed. Her phone number with directions to her house was taken. The day for the next visit was scheduled on the 27th October, 2021. She was thanked for her cooperation and the following drugs were given to her:

Tablet of Ferrous sulphate 200mg daily for 30days.

Tablet of folic acid 5mg daily for 30days.

Tablet of multivitamin 200mg daily for 30days.

Client was informed of her next visit which was on 27th October, 2021. Client was also encouraged to report any problem like severe headache, vaginal bleeding and swelling of the lower limbs, severe abdominal pains and excessive vomiting immediately. All activities carried out and findings were recorded and reported.

FIRST ANTENATAL HOME VISIT

First home visit to Madam Doreen house was on the 23th October, 2021 at 4:00pm. The main aim was to know where she lives, check on how she was coping with pregnancy, meet members of her family, observe her physical environment, listen to her complains and address the needs of her family and her and educate her on birth preparedness and complication readiness plan. The journey was made by a Taxi because the client house is quite far from the hospital per directions given by her. It was located at Mpuasu near the Presbyterian Church of Ghana. A seat was offered, a glass of water was served after which interaction with client started. Introduction was made to the family. She was very glad for the visit. Her children by then were inside because it wanted to rain. And client was there with her husband preparing food for the family. Client lived in a boys quarters house. The house was built with blocks and roofed with aluminum sheet. There were three bed rooms, whiles

the toilet and bath were outside. The house was painted in pink colour. Client and her husband sleeps in one room while their son and daughter sleeps in a different room. Their surroundings were neat and not bushy. She uses plastic container with lid to collect her refuse and empties her bin when full.

They have a pipe in which they fetch water from and electricity as a source of light. They use pure sachet water as their drinking water. Water use for other purposes such as cooking, bathing, washing is stored in a blue coloured barrel covered with a lid. Layette was brought for inspection and it was complete. She was congratulated for purchasing all the items and was advised to add her National Health Insurance card, ANC card and a purse of money and also arrange for transportation and a car in case of emergency. Education was also given on the need to sleep under treated mosquito net to prevent contracting malaria. As advise that, malaria infection can result in complication in pregnancy. Client was educated on the signs of labour, and the progress of labour. she then complains of difficulty emptying of her bowls, education was done on the reason of her condition and encouraged her to take enough water, eat fruits like oranges, water melon and any fruit of her choice to help prevent constipation and She was also educated on the intake of a well-balanced diet, the importance of having enough sleep and rest, lifting of light loads and wearing of loose cloths and low heel shoes. She was again encouraged to keep up on her environmental hygiene and was informed of her next visit. Permission was sought to leave and was granted. She was thanked for her cooperation and willingness to go by the advice

PHYSICAL ENVIROMENT

A quick assessment of the environment was done. Her children by then were playing on the compound. Client lived in a self-contained house. The house was built with blocks and roofed with aluminum sheets. There were 3 bedrooms, kitchen and toilet and bath. They had .

The client has fenced her veranda with iron rods. Outside the house is painted with pink color while inside of her room is painted with blue and white color. Client and her husband have their room whiles her child sleep in a different room. The other two rooms where been occupied by her children and her younger sister who help her with the house chores respectively. Their surroundings were neat and not bushy. She uses plastic container with a lid to collect her refuse and empties her bin when it is full into a container which is provided by Zoom lion Ghana Limited. The Zoom lion people often empty this container whenever it was full.

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

As the interaction continued, she was educated on the intake of a well-balanced diet, the importance of having enough rest, lifting of light loads and wearing of loose cloths and low heel shoes. She was again encouraged to keep up on her environmental hygiene. Her sister arrived just as the discussion was about to be concluded. She was advised to give a helping hand to the client to reduce tiredness and promote adequate rest and sleep. Her mother was advised to help in caring for the child. She was informed about the next visit which was on the 27th October, 2021. Permission was sought to leave. She was very grateful. She was thanked for her co-operation and willingness to heed the advice out.

1.9 **PSYCOSOCIAL HISTORY**

Madam Konadu Doreen lives in a boys quarters house which was built with blocks and roofed with aluminum sheet. The house contains three bed rooms, whiles the toilet and bath

was outside. Outside the house was painted in pink colour. Client and her husband sleep in one room while their two children sleep in a different room. She sweeps her compound every morning and washes her cooking utensils as well. Her kitchen is situated in the house as well. They have pipe in which they fetch water and electricity as a source of light. They use pure sachet water as their drinking water. She is very friendly with her neighbors and people who live in the same area with. Client listen to music and watch television at her leisure time.

SUBSEQUENT VISIT TO THE CLINIC BY THE CLIENT

Madam Doreen reported to the hospital on the 27th October, 2021. As scheduled. Client was asked of her previous complains and she confess that she can now pass stool freely. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows;

Temperature - 36.0oc

Pulse - 82bpm

Respiration - 20cpm

Blood pressure - 110/60mmHg

Other investigations were recorded as follows;

Haemoglobin - 12.8g/dl

Weight - 77kg

Client was asked to empty her bladder, midstream urine sample was tested for protein and sugar and it was negative.

Madam Doreen was helped onto the examination couch and privacy was ensured. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination the symphysio-fundal height was 36cm and her gestational age was 38weeks.On lateral palpation the position was right occipito-anterior. On auscultation, the fetal heart rate was 130bpm with regular rhythm and good volume.

All findings were communicated to her and recorded in her antenatal card. Routine hematinic were given and she was advised to take them regularly as prescribed and reports after a week**.**

SECOND ANTENATAL HOME VISIT

On the 30th October, 2021 at 4:30pm madam Doreen was paid a visit as promised. A cheerful welcome was given by client. Client's husband was meet; they were all happy after exchange of pleasantries, she complained of heart burns. Client was educated on the low intake of fatty and spicy foods; she was also encouraged to lie on the left lateral position. Client was reassured and the physiological change in pregnancy was explained to disappear after delivery. Client was reminded on the true signs of labour and education was given to her to have enough rest and sleep, intake of fluid and nutritious food as she also complained of feeling fatigue. We then discussed about postpartum family planning and her husband said they were interested in it.

SUBSEQUENT VISIT TO THE HOSPITAL BY THE CLIENT

Madam Doreen reported to the hospital on the 3rd November, 2021. As scheduled. She was helped through the normal routine procedures and her vital signs were checked and recorded as follows;

Temperature - 36.5oc

Pulse - 85bpm

Respiration - 24cpm

Blood pressure - 110/60mmHg

Other investigations were recorded as follows;

Hemoglobin - 12.9g/dl

Weight - 78kg

Client was asked to empty her bladder, midstream urine sample was tested for protein and sugar and it was negative.

Madam Doreen was helped onto the examination couch and privacy was ensured. General examination was carried out under the supervision of the midwife in-charge and no abnormalities were found. On abdominal examination the symphysio-fundal height was 37cm and her gestational age was 39weeks. On lateral palpation the position was right occipito-anterior. On auscultation, the fetal heart rate was 138bpm with regular rhythm and good volume.

All findings were communicated to her and recorded in her antenatal card. Routine hematinic were given and she was advised to take them regularly as prescribed and she was asked to come for next visit on the 10th November, 2021.

SUBSEQUENT HOME VISIT

Subsequent visit to client house was on 6th November, 2021 at 4:00pm as it was booked. The purpose of the visit was to inquire about the client health status and also condition of the family. Madam Doreen received me in a warmly manner on arrival with a cheerful face and greetings were exchanged and a seat offered. An enquiry was made about client health status and a positive response was given. Client also said the whole family were doing well but she complained of lower abdominal pain. This physiology was explained to the client that it was due to the descent of the fetal head. She was then encouraged to take enough rest and that the pains will disappear after delivery. Client's environment was clean and tidy and the refuse had been emptied. Inspection of the client's rooms was done and it was observed and the mosquito nets were well hanged. Client was asked to report to the hospital whenever she is not well and was reminded of her next visit to the hospital which was on the 10th November, 2021. She was thanked for her cooperation and permission was sought to leave.

NURSING CARE PLAN DURING ANTENATAL CARE

Nursing care plan is a plan of care that is designed to guide and provide continuous care to the client by midwife. It involves identification of problems, making of nursing diagnosis of the problem identified, setting of objectives regarding the client, taking actions to solve the problems identified and evaluating the objectives that were set. In the course of this care study, five nursing care plans were identified for Madam Doreen that was for antenatal, labour, and puerperium.

PROBLEMS IDENTIFIED DURING ANTENATAL CARE

Client complained of:

1. Waist pain on the 3rd October, 2021.

2. Constipation on the 27th October, 2021.
3. Heartburns on the 27th October, 2021.
4. Fatigue on the 20th October, 2021.
5. Lower abdominal pains on the 3rd October, 2021.

SHORT TERM OBJECTIVES

- Client waist pain will be reduced within 24hours.
- Client will be able to empty her bowl at least once within 24hours.
- Client heartburns will be reduced within 24hours.
- Client fatigue will be reduced within 24hours.
- Client will be able to cope with lower abdominal pains within 3 hours.

LONG TERM OBJECTIVES

Madam Doreen will go through pregnancy, labour and puerperium successfully without any complication to both mother and fetus.

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
3/11/21 11:30am	Waist pain related to relaxation of the pelvic joints.	Client's waist pain will be reduced within 24 hours as evidenced by; 1. Client verbalizing that waist pain has reduced. 2. Midwife visualizing client expressing low pain after performing	1. Reassure client to allay anxiety. 2. Educate client on the physiology of waist pain 3. Teach husband on how to do sacral massage on client. 4. 4. Encourage client to lie in the left lateral position. 5. Encourage client to apply	1. Client was reassured to allay anxiety. 2. Client was educated on the physiology of waist pain. 3. Client husband was taught how to do sacral massage on client. 4Client was encourage to lie in the left lateral position 5. Client was encouraged to applied warm compress to	4/11/21 8: 30am	Goal fully met as 1. Client verbalized that the waist pains has reduced.	A.D

		activities	warm compress to waist.	reduce the waist pain.			

ANTENATAL CARE PLAN

DATE/ TIME	**NURSING DIAGNOSIS**	**NURSING OBJECTIVES**	**NURSING ORDERS**	**NURSING INTERVENTION**	**DATE/ TIME**	**EVALUATION**	**SIGN**
27/10/21 7:00am	Constipation related to progesterone causing	Clients will regain her normal bowel movement within 24hours as evidenced	1. Reassure client to allay fear and anxiety. 2.Explain the physiology behind constipation to client	1. Client was reassured to allay fear and anxiety. 2. physiology of constipation was explained to client.	28/10/21 7:00am	Goal met as; 1. Client verbalized she	A.D

	decrease peristaltic movement of the bowls and relaxation of the smooth muscles of the intestine.	by; 1. Client verbalizing that she is able to empty her bowels freely. 2. Client husband verbalizing that his wife can empty her bowel freely.	3. Educate client on the intake of food rich in fiber 4. Encourage client to take a lot of fluids every day. 5. Encourage client to exercise regularly	3. Client was educated on the important of food rich in fiber. 4. Client was encouraged to drank eight glasses of water per day. 5. Client was encouraged to exercise regularly.		has resumed her normal bowel movement once daily. 2. Client husband confirmed what his wife said.	

ANTENATAL CARE PLAN

DATE/TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
27/10/21 9:00am	Heart burns related to effect of progesterone causing relaxation of the cardiac sphincter during pregnancy.	Client's heartburns will be relieve within 24hours as evidence by; 1. Client verbalizing that she is relieved of heartburns. 2. Midwife observing that client expressed no sign of burning sensation.	1. Reassure client that her heart burns will be relieved. 2. Educate client on the physiology of heart burns. 3. Encourage client to reduce the intake of oily and spicy food. 4. Encourage client to avoid strenuous exercise 5Teach client to sit upright during and after eating	1. Client was reassured that her heart burns would be relieved 2. Physiology of heart burns was explained to the client. 3. Client was educate to reduced intake of oily and spicy food. 4. Client was educated to avoid strenuous exercise	28/10/21 9:00am	Goal fully met as evidenced by client told the midwife that her heart burns has been relieved.	A.D

				5. Client was taught to sit upright during and after eating/			

ANTENATAL CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	OUTCOME/ OBJECTIVE CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
20/10/21 9:30am	Fatigue related to weight of the growing feotus and stress from work	Madam Doreen fatigue will subside within 24hours as evidence by; 1. Client verbalizing ability to cope with weight of product of	1. Reassure client that her fatigue will reduce. 2. Encourage family members to help with household chores. 3. Teach client energy	1. Client was reassured that her fatigue will reduce. 2. Family members were educated to assist in household chores.	21/10/21 7:30am	Goal met as evidenced by; 1. Client verbalised ability to cope with daily weight of product of conception and	A.D

		conception and reduced stress of work. 2. Midwife observing client ability to cope with the weight of product of conception and reduced stress from work through client's body language.	conservation techniques such as sitting rather than squatting or standing whiles working. 4. Encourage client to have adequate rest and exercise during the day. 5. Encourage client to engage herself in mild exercise to help relieve her from some stress in pregnancy.	3. Client was seen sitting rather than squatting or standing whiles working. 4. Client rested for at least 30minutes during daily activities. 5. Client engaged in deep breathing exercise which helped relieved her from the stress in pregnancy.		reduced stress from work. 2. Midwife observed client's ability to cope with weight of product of conception and reduced stress from work as client looked happily on performing activities.	

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
3/11/21 10:30am	Lower abdominal pain related to descent of the fetal head.	Client's lower abdominal pain will subside within 3hours as evidenced by; 1. Client verbalizing that lower abdominal pain has subsided 2. Midwife observing that client is comfortable.	1. Reassure client to allay fears and anxiety. 2. Explain the physiology of lower abdominal pains to client. 3. Encourage client to wear low heel shoes. 4. Encourage client to have adequate rest and sleep. 5. Serve client with	1. Client was reassured to allay fears and anxiety 2. Lower abdominal pain was explained to client that it was due to the descent of the fetal head. 3. Client wore low heeled shoes throughout pregnancy. 4. Client was encouraged to have at	3/11/21 12:00Pm	Goal fully met as 1. Client verbalizing that her lower abdominal pain has subsided. 2. Midwife observing that, client is now comfortable in bed.	A.D

			prescribed analgesic (paracetamol).	least 2hours rest and sleep during the day and 6hours in the night. 5.Client was served with 1G of paracetamol.			

CHAPTER THREE:

LABOUR

Introduction

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

ADMISSION AND MANAGEMENT OF LABOUR

Admission

On 8th November, 2021 at 8:00am, Madam Doreen arrived at Adamsu Health Center with her sister per ambulatory. They were warmly welcomed and seats offered to them. She complained of severe lower abdominal pains, painful uterine contractions and client said she had noticed some mucoid blood stain vaginal discharge (show) before coming. Madam Doreen was taken to the delivery room and the sister was given a chair to sit on outside. It was not long before that, when the mother also arrived at the clinic. At the delivery room, client was oriented and wash room was shown to her, she was offered a bed. Procedures to be done were explained to client and her consent was given. Her vital signs were checked and recorded as follows;

Temperature	36.2degree Celsius
Pulse rate	87 beats per minute
Respiration rate	20cycles per minute
Blood Pressure	110/60 millimeters of mercury

Client was served with a bedpan to empty her bladder and a specimen bottle for mid-stream urine. The amount of urine produced was about 150mls. She was assisted unto the couch;

hands were washed and dried with a clean dry towel. Client was examined from head to toe and no abnormalities were detected.

Client abdomen was ovoid in shape and medium in size. Striae gravidarium, linear nigra and fetal movement were present but no scar was found.

The abdomen was palpated, symphysio fundal height was 38cm, and gestational age was 39weeks+2days the lie was longitudinal, presentation was cephalic and descent was 3/5th palpable abdominally. Contraction was 2 in 10minutes lasting thirty (30) seconds.

The foetal heart rate was 140beat per minute with good volume and regular in rhythm.

Permission was sought from Madam Doreen for vaginal examination which she agreed. . Hands were washed with soap under running water and dried with a clean dry towel. A tray already set had sterile gloves, a receiver for the used swabs, clean perianal pad and two sterile gallipots with one containing sterile cotton while the other contained savlon lotion. Client was assisted to assume a dorsal position with the knees flexed and a mackintosh and towel placed under client. Hands were washed a pair of sterile gloves were worn and client was draped afterwards. She was asked to expose vulva. The vulva was inspected for oedema, scars and varicose veins but there was none present. Five (5) sterile cotton wool swabs were used for the examination. The dominant hand was used to pick the cotton wool and dipped into savlon solution; swab was dropped from the dominant hand into the non-dominant hand and swabbed per stroke from upwards-downwards starting with the labia majora.

The labia majora was swabbed from upwards-downwards and the used swab was disposed of into a receiver. The labia minora was swabbed also from upwards-downwards and the used swab was disposed into a receiver. The vestibule was patted and cleaned using the non-dominant hand. A swab was used to wipe the vestibule from upwards-down; the used swab was disposed into the receiver. Using the dominant hand, the middle and index fingers were

inserted gently into the vagina pressing firmly downwards.. The condition of the vagina was warm and moist and the cervix was soft, thin and well applied to the presenting part. The cervix was effaced and dilatation was five (5) centimetres at 8:15am. Ischia spines were blunt and pubic arch was wide, sacral promontory was not reached at 12 centimetres. Membranes were intact and there was no moulding (0). The inserted fingers were withdrawn and observed but nothing abnormal was seen. A clean perineal pad was applied on the vulva and client was asked to lie on her left side to prevent supine hypotension syndrome. Client was tidied up neatly and placed in a comfortable position. All findings and the progress of labour was explained to client using the dilatation board . Client was thanked for her cooperation and made comfortable in bed. The tray was discarded, hands were washed under running water with soap, dried with a clean dry towel and all information gathered was recorded on a partograph sheet around 8:18 am.

preparation for birth

In preparing for birth, a helper was identified, that was skilled and unskilled helper. The skilled helper was the Midwife-In-Charge who would supervise labour and delivery as well as the care of the baby and mother. A second skilled helper was a ward assistant. The ward assistant who would assist in times of need. The emergency plan was reviewed. The contact numbers of the referral hospital were active when checked as well as the ambulance. Madam Doreen was informed that after delivery baby would be placed on her chest for skin to skin contact for one hour of which she responded positively. She was asked to wash her hands, chest and abdomen to prepare for skin to skin care prior to the second stage of labour. The area for delivery was also prepared. Client was told that, the windows and doors will be closed, curtains were drawn down and fan put off when delivery is eminent to provide warmth for the baby and also privacy.

Hands were washed thoroughly with soap and water to prevent the spread of infection. A dry, flat resuscitation area was prepared in case the baby will need any ventilation. The equipment to help babies breathe was assembled in the area for ventilation and their functions tested especially the ventilation bag and mask. The delivery trolley was set and the entire instruments needed for the delivery were assembled, a cot was prepared for the baby.

MANAGEMENT OF FIRST STAGE OF LABOUR

Madam Doreen was encouraged to assume any position favorable but not harmful to her. She was encourage to possibly assume a left lateral position to increase placental perfusion and prevent supine hypotension. She was encourage to ambulate to aid in decent of the fetal head. A bed pan was provided for her and was encouraged to urinate when she feel the urge to urinate which will help aid in decent of the fetal head. Client was also encouraged to take in water or any fluid to prevent dehydration.

Client was put on partograph on admission when labour was established fetal heart rate, contractions and maternal pulse were checked every 30 minutes and vaginal examination, descent, blood pressure, moulding, membrane and temperature were checked 4hourly.Urine test for protein and acetone was checked for every (4) hourly. At 8:45am fetal heart rate was 140bpm, contraction were 2:10 lasting for 32sec, and maternal pulse was 86bpm.At 9:15am fetal heart rate was138bpm, contraction 3:10 lasting for 32sec and maternal pulse was84bpm. At 9:45am fetal heart rate was142bpm, contraction 3:10 lasting for 35sec, maternal pulse 80bpm. At 10:15am fetal heart rate was 140bpm, contraction were 3:10 lasting for 36sec and maternal pulse 82bpm. At 10:45am featal heart rate were 142bpm contraction 4:10 lasting for 38sec and maternal pulse were 81bpm. At 11:15am fetal heart rate were 140bpm, contraction 3:10 lasting for 42sec and maternal pulse were 82bpm. Client was given porridge as she was complaining of hunger. She was educated not to reuse pad when it falls. She was encouraged

to do deep breathing exercise when contractions comes and also to avoid pushing during contractions since the cervix would not be fully dilated and to prevent the risk of edematous cervix.

All findings were plotted on the partograph and progress of labour was communicated to her and she was reassured. The delivery trolley which contains the following items was made ready:

TOP SHELF

Delivery pack containing; four clean towels

Two artery forceps

Two dissecting forceps

Two gallipot (with one containing cotton swabs soaked in savlon solution and the other containing gauze)

One cord scissor

Receiver

Episiotomy set

Cord clump

Pair of sterile gloves

10 units of oxytocin

Two cot sheet

Vitamin k injection

LOWER SHELF

A jug for measuring the amount of blood loss

Receiver for placenta

Container with syringes and needles

Fethoscope

Antiseptic lotion (savlon)

Sterile gloves

Extra perineal pad

Small cup containing water and bulb syringe

Cord clamp

Bed pan

Identification band

Examination gloves

Mackintosh

Cot sheets

Drum containing gauze and cotton wool

Cheatle forceps in its container

At 11:45am fetal heart rate were 142bpm, contraction were 3:10 lasting for 42sec and maternal pulse 83bpm Client was assisted to lie on her left side and breath through her mouth since she was complaining of severe waist pain. She was reassured that she will soon have her baby and all discomfort will be resolved and a sacral massage was given to reduce the pain. Bedpan was provided for her to empty the bladder frequently to enhance effective contractions and descent of the foetal head since full bladder could slow down the progress of labour. Client was encouraged to assume a favorable position which will not cause harm to the fetus and physiology of uterine contraction was explained to her. . At 12:15pm fetal heart rate were 140bpm, contraction 4:10 lasting for 45sec and maternal pulse were 83bpm. Temperature was checked and recorded as 36.9 degree Celsius and blood pressure

was110/60mmHg, urine was taken to test for protein and acetone and they all showed negative and the amount as100mls and head decent was 1/5 above the pelvic brim. Client's membrane raptured spontaneously at 12:10pm so vaginal examination was repeated as she was already due and vagina was warm and moist, the cervix was 9 centimeters (cm) dilated and well applied to the presenting part with amniotic fluid clear and moulding was (+). Hands were washed with soap under running water and dried with a clean dry towel. All findings were plotted on the partograph and progress of labour was communicated to her and she was reassured. . Client was given porridge as she was complaining of hunger.

At 12:45 pm, fetal heart rate was140bpm, contraction 4:10 lasting for 50sec, maternal pulse 85bpm. At 1:15pm, fetal heart rate was140bpm with good volume , contraction 5:10 lasting for 52sec maternal pulse 84, client then complained of bearing down. V/E was repeated immediately and the cervical os was fully dilated that is 10cm and descent was $0/5^{th}$. Amniotic fluid was clear and moulding was two (++),The Midwife in- charge was informed about the progress of labour and also asked to confirm the findings and she said Madam Doreen's cervix was fully dilated. Findings were recorded on the partograph sheet and client was informed of full dilatation of the cervix around 1:17. Madam Doreen was remaindered again that the baby would be delivered onto her abdomen for skin to skin contact as well as to establish bonding. This marked the beginning of the second stage.

MANAGEMENT OF THE SECOND STAGE OF LABOUR

A chart was shown to client to select the position which she would like to assume in the delivery of the baby and client selected the lithotomy position. She was assisted to assume the lithotomy position with a pillow supporting the back and her legs well supported on the bed. After putting on the protective clothing, hands were washed thoroughly with soap and water and dried with a clean sterile towel. The already prepared delivery trolley containing the

needed it ems was pulled nearer to the delivery bedside and the sterile towel covering the top shelf of the trolley removed. Delivery pack was opened by an assistant and a pair of sterile gloves was worn. The vulva was cleaned with savlon solution as well as the upper thighs. Client's abdomen and thighs were draped with a sterile dry towel. She was again encouraged to push with contractions, rest in between contractions and adhere to instructions at this stage. Client complained of excessive sweating and a dump towel was used to mop her face and also encourage to drink cold malt. A clean perineal pad was then applied to the perineum to prevent fecal matter from contaminating the baby's face. As the foetal head was advancing, the index and middle finger was placed on the foetal head to aid flexion and to allow the smallest diameter of the fetal head to distend the vulva. This was done to prevent perineal tear. The head crowned and client complains of fatigue and she was asked to breathe through her mouth, the sinciput, face and chin swept the perineum and the head was delivered by extension. One finger was quickly used to feel for cord around neck but there was none. The baby's eyes, mouth and nose were wiped off gently with sterile gauze as well and the airway was cleared with a penguin. Restitution and external rotation of the head took place which indicated internal rotation of the shoulders to lie in the anterior posterior diameter. The head of the feotus was held in both palms on each side of the biparietal bones and a downward traction was applied to allow the anterior shoulder to be slipped under the pubic bone. The posterior shoulder was delivered by an upward traction towards the mother's abdomen by lateral flexion, the trunk and the rest of the body were delivered onto the mother's abdomen as explained to her. This was to help in skin to skin contact as well as providing warmth and bonding between the mother and the baby. The Midwife-In-Charge who was supervising the delivery noted the time of delivery as 1:25pm. A healthy baby boy was delivered and sex confirmed by the mother. She was congratulated for her effort and co-operation.

IMMEDIATE CARE OF THE BABY AT BIRTH

Soon after birth, the baby cried, the baby's eyes were cleaned with sterile gauze from inner cantus to outer cantus. Mouth and nose were suctioned with a bulb syringe to help clear the airway. The cord was clamped 3centimetres from the baby's abdomen, and 2 centimetres from the first clamp. Cord clamp was applied and artery forceps removed. The baby was dried thoroughly and placed on mother's chest covered with towel to promote skin to skin contact. Identification band with name, sex, date and time of delivery was placed on the baby's wrist to help distinguish him from other babies. He weighed 3.8kg, Head circumference was 34 centimeters, length 54 centimeters, temperature 36.6 degree Celsius vitamin K was given to the baby to stop bleeding. Baby was placed on the mother chest to initiate bounding between the mother and baby. The head of the baby was covered with cap to provide warmth .The baby was left on the mother's chest in skin to skin contact for an hour.

MANAGEMENT OF THE THIRD STAGE OF LABOUR

Client still in the lithotomy position , a gentle palpation was done on the uterus to exclude undiagnosed fetus but there was none. Ten (10) units of oxytocin was given intramuscularly on the thigh at 1:26pm to aid in the contraction of the uterus, the cord was clamped near the perineum with the artery forceps with a receiver placed in between the mothers thighs to receive the placenta. The clamped cord was held with the dominant hand whiles the non-dominant hand was placed above the fundus to feel for contractions. When a uterine contraction was felt, the non-dominant left was placed on the lower abdomen in the supra pubic area just above the symphysis pubis and counter traction applied to support the uterus to prevent uterine inversion whiles controlled cord traction was used in delivering the placenta until it was visible at the introitus. The non-dominant hand was released and both hands were used in receiving the placenta and gentle twisting movement was made to ease

pressure on the membranes till fully. The placenta and its membranes were delivered at 1:30pm. The placenta was placed in the palms and quick examination was done to detect any retained product of conception but none was detected. It was then placed in a receiver to be properly examined in the sluice room. The uterus was massaged immediately after the delivery of the placenta to aid uterine contraction, arresting haemorrhage as well as expelling clots. Gauze was wrapped around the index and middle fingers to inspect the cervix, vagina and perineum to exclude tears and lacerations. The cervix and the vaginal wall were inspected using the clockwise method and the perineum was intact. There were no tears found in the cervix, the vaginal wall, the vulva nor the perineum. The estimated blood loss is 150mil. Client was cleaned and made comfortable by applying a clean perineal pad to the perineum to absorb lochia drainage. The mother and baby were covered with a piece of cloth to ensure an hour effective skin to skin contact.

Madam Doreen was encouraged to empty her bladder whenever she has the urge for the uterus to contract well and she was also taught how to massage the uterus herself and report any changes quickly. She was made comfortable in bed and congratulated for the effort made. All findings were recorded on the partograph.

EXAMINATION OF THE PLACENTA AND MEMBRANES

The placenta was dip in 0.5 chlorine and removed immediately. The placenta was examined under a good source of light and on a flat surface. The placenta was held by the cord and the length measured was 48centimeters long. The fetal surface was greyish blue with firm amniotic membranes and cord was in the center of the placenta. The maternal surface was dark red in color. It was covered with chorine which was opaque. The membranes, lobes and cotyledons were inspected and they were intact. No infarct and oedema were seen on the maternal surface, the cord was thick with Wharton's jelly. The tip of the cord was wiped with a dry cloth for insp ection. It had two arteries and one big vein. The placenta was placed in

0.5% chlorine solution in the sluice room for decontamination and discarded in the placenta pit. The delivery instruments and equipment used were soaked in 0.5% chlorine solution, gloves were removed and hands were washed. After 10 minutes, instruments were removed with utility gloves, washed in soapy water and rinsed in clean water and was then air dried and packed for sterilization. Estimated blood loss was 150 milliliters. Madam Doreen was informed about the findings and necessary documentations were made.

EXAMINATION OF THE NEWBORN

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

Head and neck: On examination of the head, the index and middle fingers was run through the suture line to check for any bulging fontanelles but no abnormality was detected. There was no laceration on the scalp and no caput succedaneum. The ears were examined for size, shape, patency, position, softness of the cartilage but no abnormality was detected. The eyes were in alignment with the ears and presence of an eyeball. There was no redness of the conjunctiva or jaundice on the sclera. The nose was examined for shape, size, patency to rule out deviated septum and discharges but everything was normal. The mouth was examined for the presence of false teeth, cleft palate and tongue tie but there was none. Rooting, suckling and swallowing reflexes were present.

Chest and abdomen: On the chest, respiratory movement was normal, and on breast examination there was no engorgement of the breast, had no masses on palpation and the nipple was inspected for position, extra nipple and everything was normal. There was no exomphalous, distention of the abdomen, and on palpation there were no 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, abnormalities such as omphalocele and gastroschisis were absent. The skin was examined for skin color, vernix caseosa, and lanugo, peeling of the skin, rashes and birth mark but no abnormality detected.

Limbs: The upper extremities were equal with no extra digits. There were palmer creases and, no webbed fingers. Grasping and Moro reflexes were present. Hands and arms were inspected for movement, paralysis, nail beds were checked for capillary refill and everything was normal. The lower extremities were examined for equality, extra or missing digits, clubbed feet but no abnormality was detected. Congenital hips dislocation was checked using the ortolani's test. There was no dislocation since a 'clunk' was not heard.

Back: Baby was turn to the left side and on inspection there were no rashes, discoloration and hairy patches, the back was also palpated with the thumb to rule out spinal bifida or a missing vertebra but there was none.

Genitalia: On inspection of the genitalia, the scrotum and the testicles were palpated for descended testes and there were no abnormalities noticed. The urethra was centrally. Baby passed meconium and urinated soon after birth indicating the patency of the anus and urethra. Baby's weight was 3.8 kilogram, measurements of the head circumference was 34cm, and length of baby was 54cm respectively. Gloves were removed and disposed aseptically before washing and drying hands. Findings were documented and communicated to client.

The baby was warmly wrapped in with a clean dry sheet and placed beside her mother. Mother was asked to observe the baby continuously and report any abnormality.

MANAGEMENT OF THE FOURTH STAGE OF LABOUR

Client and her baby were transferred into the lying in ward after putting the baby skin to skin for an hour. Monitoring of client and baby continued strictly for six (6) hours after a successful completion of the third stage of labour.

During this stage, the mother and the baby were assessed every 15 minutes for 2 hours, 30 minutes for an hour and one hourly for three (3) hours were recorded on the post-delivery observation chart and it falls within the normal range. Mother first vitals were B/P_ 110/60, Pulse 76, Temperature 36. 7 degree Celsius.

The uterus was massaged to facilitate contractions. Blood clots were expelled and blood loss was 150 milliliters and the symphysio fundal height was 18 centimetres. At the end of the 6 hours monitoring, all findings was recorded in the post-delivery chart. Lochia was red in colour (rubra), moderate in quantity. Madam Doreen was educated on the need to micturate frequently and changing of perineal pads when soaked. Client was also thought how to demonstrate and fix baby to breast, the importance of exclusive breastfeeding for the first 6 months and to feed the baby on demand. She was also encouraged to wash hands thoroughly with soap and water before breastfeeding and after changing perineal pad. Client's mother was allowed to see her and she was served with porridge and bread to restore energy. General condition of client was good

PREVENTION OF DISEASES

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

SUMMARY OF LABOUR

Client had a spontaneous vaginal delivery to a live male baby on 8th November, 2021 at 1:25pm with birth weight 3.8kg with APGAR score 8/10 and 9/10. Placenta and membranes were completely delivered at 1:30pm by controlled cord traction. Estimated blood loss was 150mls. Condition of mother and baby was satisfactory and they were made comfortable in bed.

3.10 CONDITION OF BABY AT BIRTH

The general examination of baby was done and no abnormalities detected.

Temperature	36.8 degree Celsius
Respiration	40 cycles per minute
Apex beat	128 beat per minute
Weight	3.8 kilogram
Length	54centimeters
Head circumference	34centimeters
Sex	Male

OTHER ASSESSMENT INCLUDE

APGAR score for the first minute of birth

Appearance/Colour	1
Grimace/reflex	1
Activity/ muscle tone	2
Respiration	2
Pulse/heart beat	2
Total	8/10

APGAR score the fifth minute of birth was.

Appearance/colour	2
Grimace/reflex	1
Activity/muscle tone	2
Pulse/heart beat	2
Respiration	2
Total	9/10
Meconium	Passed
Urine	Passed
General condition	Very Good
Abnormalities	None detected

CONDITION OF MOTHER AFTER BIRTH

Client was made comfortable in bed and was helped to fix baby to the breast. Uterus was well contracted and her condition was good. Client's initial vital signs were checked and recorded as well as other examinations done as;

Temperature	36.2 degree Celsius
Pulse	86 beats per minute
Respiration	20 cycles per minute
Blood pressure	110/60 milliliters of mercury
Symphysio fundal height	18 centimetres
Blood loss	150 milliliters

CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED DURING LABOUR:

On the 8th November, 2021, client made the following complains;

1. Lower abdominal pain
2. Seen anxious
3. Waist pain
4. Excessive sweating

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pains within 3 hours
2. Client's anxiety will reduce within 3 hours
3. Client will cope with waist pain within 2hours
4. Client will maintain adequate fluid volume throughout the 2nd stage of labour

LONG TERM OBJECTIVES

Client and baby will go through all the stages of labour and puerperium successfully without any complication to both mother and baby.

LABOUR CARE PLAN

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
8/11/21 9:05pm	Lower abdominal pains related to painful uterine contractions and descent of foetal head	Client will cope with lower abdominal pains during labour within 3 hours as evidenced by; 1. Midwife observing that client can cope with pain	1. Reassure client to ally fear and anxiety 2. Encourage client to practice deep breathing exercise. 3. Explain the physiology of pain to her in simple terms 4. Massage client sacral region 5. Encourage client to perform mild exercise such as walking	1. Client was reassured to ally fear and anxiety. 2. Deep breathing exercise was performed by client. 3. Physiology of pain was explained to her in simple terms. 4. Client sacral region was gently massaged as thought to promote comfort. 5. Exercise such as walking was performed by client as mild exercise.	8/11/21 12:10pm	Goal fully met as midwife visualized client having a relaxed facial expression.	A.D

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
8/11/21 9:00am	Anxiety related to unknown outcome of labour.	Client anxiety level will reduce within the next 3 hours as evidenced by 1. Client verbalizing that she is no longer anxious. 2. Midwife observing that client is no more anxious by facial expression	1. Reassure client to allay her fears and anxiety. 2. Establish and maintain good interpersonal relationship with client. 3. Explain to client about the progress of labour and clarify all misconception 4. Encourage deep	1. Client was reassured to allay fear and anxiety. 2. Good interpersonal relationship with client was established and maintained 3. Progress of labour and clarifications of all misconception was explained to client 4 Client was encouraged to perform deep breathing exercise. 5. Client was allowed to ask questions and express her	8/11/21 12:30pm	Goal met as 1. Client verbalized that she was no more anxious. 2. Midwife observing that client was relaxed in bed.	A.D

			breathing exercise. 5. Encourage client to ask questions and answer them tactfully.	worries and explanations were given accordingly.			

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/TIME	EVALUATION	SIGN
8/11/21 9:30am	Waist pain related to pressure of the descending feotus on the sacral nerves	Client will cope with waist pain within 2hours as evidenced by 1. client stating one of the coping measures of waist pain 2. Midwife visualizing that client has a cheerful face.	1. Reassure client that she would be relieved of her waist pains. 2. Explain the physiological changes behind waist pains during labour to client. 3. Massage the client's sacral region to relieve her of waist pain 4. Engage client in a divisional therapy(conversation) 5. Encourage and assist client	1. Client was reassured that she would be relieved of her waist pains. 2. The physiology behind waist pain during labour was explained to client. 3. Sacral massage was performed on client to relieve her of waist pains. 4. Client husband was allowed to talk to her to relieve her mind off the pains. 5. Client adopts a left lateral	9/11/21 7:00am	Goal fully met as client verbalized that she is no more tired.	A.D

			to adopt a comfortable position.	position.			

LABOUR CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
8/11/21 11:00am	Risk for fluid volume deficit related to profuse sweating	Client will maintain adequate fluid volume throughout the second stage of labour within 12 hours as evidenced by 1. client shows no signs of dehydration 2. Midwife observing client is not dehydrated.	1. Reassure client that her fluid volume will be maintained. 2. Serve sips of nourishing drinks at regular interval. 3. Wipe clients face and body with cool damp towel. 4. Monitor clients intake and output 5. Observe client for signs of	1. Client was reassured that her fluid volume will be maintained 2. Client was served with nourished drinks such as malt at regular interval. 3. Clients face and body were wiped with a cool damp towel. 4. Clients intake and output	8/11/21 5:20pm	Goal met as; 1. client showed no signs of dehydration 2. Midwife observing client will not show signs of dehydration.	A.D

			dehydration such as dry and cracked lips.	was monitored on a chart. 5. Signs of dehydration such as dry and cracked lips were observed.			

CHAPTER FOUR

PUERPERIUM

INTRODUCTION

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

DAY OF DELIVERY

After delivery of the placenta and membranes, Madam Doreen and her baby were transferred to the lying-in ward at 2:35pm after postpartum check when her condition and that of the baby was stable. She was given bread and porridge to eat for energy. She was encouraged to empty her bladder frequently to avoid postpartum haemorrhage as well as breastfeeding baby frequently to help the uterus to contract. The vital signs were monitored for every 15 minutes for the first 2 hours, every 30 minutes for the next 1 hour and hourly for the last three hours.

Her vital signs were checked and recorded as follows:

Temperature	36.2 degree Celsius
Pulse	82 beats per minute
Respiration	20 cycles per minute
Blood pressure	110/70 mmHg

Her symphysio fundal height measured 18 centimetres. The uterus was checked for involution and the perineum was also checked for any active bleeding at this time. Lochia was bright red in colour (rubra) and the flow was normal. Client was encouraged to change perineal pad frequently when soiled to avoid infection as well as wash her hands with soap and water after changing the pad. She was taught how to massage the uterus by rubbing the palm on the fundus to help in the involution of the uterus and arrest haemorrhage. She was also educated on exclusive breastfeeding for 6 months and on demand as this would help the baby to grow well. Client was also taught to perform pelvic floor muscles and abdominal exercises to strengthen the muscles and also to aid involution. Head to toe examination was done on the mother and no abnormality was detected. She complained of fatigue and was encouraged to have enough rest. Later, she was assisted to the bathroom to take her bath. She felt good and refreshed after bathing.

SUBSEQUENT CARE OF THE BABY

After six (6) hours of observation (8:00pm), baby was given warm bath and his cord dressed with methylated spirit and cotton wool swabs. Head to toe examination was also done and no abnormality was detected. The baby was wrapped in a warm dry sheet to maintain body temperature and he was also placed beside his mother to breastfeed. The vital signs and other measurements were taken and recorded as follows:

Temperature	36.0 degree Celsius
Apex beat	124 beats per minute
Respiration	42 cycles per minute

Weight 3.8 kilograms

Length 54 centimetres

Head circumference 34 centimetres

All findings were communicated to Madam Doreen and recorded.

BABY BATH AND CORD DRESSING

REQUIREMENTS

Soap

Sponge

Surgical gloves

Cream/powder

Sterile cotton wool swabs and gauze in a gallipot

Towels, 1 big towel and 3 small towels

Cot sheets 2

Plastic apron

A clean baby dress, cap and socks

2 jugs containing hot and cold water each

Two receptacles for used water and dirty linens

PROCEDURE

All procedures were explained to the mother and she consented. She was also asked to observe how the procedure was done.

A plastic apron was worn. The hands were washed with soap and water under running water and dried with a clean dry towel.

Both cold water and hot water were missed together and the temperature of the water was checked using the elbow where client also confirmed. Examination gloves were worn and the baby was taken from his mother. The baby was put on a flat surface and the mother was given a seat to observe the procedure. The baby was undressed and quick observation was made before baby was wrapped with a cot sheet. His eyes were cleaned with cotton wool swab soaked in sterile water from the inner canthus to the outer canthus of each eye using separate cotton wool swabs. His face was cleaned with a damp face towel and dried. The nape of the neck was supported with one hand. The baby's ears were plugged with the middle finger and thumb to prevent water from entering into the ears. The head was washed with soapy sponge, the baby was lifted off the flat surface with the body resting in the elbow and still supporting the nape, the washed head was rinsed with clean water and was then dried. The baby was placed on the flat surface with the body been exposed. The neck, arms and front of trunk were bathed paying attention to the skin folds. The back was turned with one arm supporting the chest and the other hand bathing the back down to the feet, paying attention to the skin folds. The baby's body was supported firmly and was immersed into the warm water with the head supported above the level

of the water. The body was rinsed thoroughly. The baby was removed from the water onto the working surface and was covered with clean dry cot sheet. The wet cot sheet was removed and a clean dry towel was used to dry the baby paying attention to skin folds. Baby oil was smeared on the body and the baby was dressed up. The gloves were removed and hands were washed with soap under running water and dried with a clean dry towel.

CORD DRESSING

Sterile gloves were worn and the cord was exposed and was inspected for bleeding and looseness but there was none. Five (5) cotton wool swabs were soak in methylated spirit. The tip of the cord was held with sterile cotton wool swab, the base of the cord was then cleaned with separate cotton wool swab. The whole cord was cleaned from the base upwards and lastly the tip was also cleaned with separate cotton wool swab. The cord was left exposed to air dry. Gloves were removed and Hands were washed with soap under running water and dried with a clean dry towel. Baby was dressed and wrapped with clean dry cot sheet to maintain his temperature and was given to his mother. Client was thanked for her co-operation and she was accompanied to the bedside. Her things were packed and used items were discarded. The working surface and the instruments used were decontaminated with 0.5% chlorine solution for 10 minutes. Hands were washed with soap under running water and dried with a clean dry towel. Findings were communicated to the mother and were documented. The mother was encouraged not to touch or apply anything to the cord. She was taught and encouraged only to dress the cord with clean cotton wool swabs and methylated spirit.. She was also encouraged to breastfeed the baby anytime baby wants to feed and allow him to empty one breast completely before he takes the other.

FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

9th November, 2021 happens to be th e first day after delivery. Madam Doreen and baby were in good health.

The baby was being breastfed and he was suckling well. Permission was sought later to examine the baby. Hands were washed with soap under running water and dried with a clean dry towel. On general examination, there was nothing abnormal detected. The baby was top and tailed, dressed and wrapped nicely in the presence of the mother and her husband. The cord was dressed with 5 sterile cotton wool swabs soaked in methylated spirit. The baby passed urine and meconium which was normal. The mother was educated not to apply hot compress on the fontanelles with the intention that it is a wound and with the hot compress it would heal. It was explained to the family that the fontanelles would close by themselves. That is the anterior fontanelles will close by18 months and the posterior fontanelles will also close by 6 weeks. Client was encouraged to keep the cord clean and to prevent using local herbs. She was also educated on the provision of warmth, maintaining temperature and prevention of infection. Baby vital signs and weight were checked and recorded as follows:

Temperature	36.7^0c
Apex beat	124bpm
Respiration	48cpm
Weight	3.7kg

Mother's vital signs were checked and recorded as:

Temperature	36.6 ^{0}c
Pulse	76bpm
Respiration	21cpm
Blood pressure	100/60 mmHg

Procedures to be done were explained to madam Doreen and she consented. Head to toe examination was done and nothing abnormal was detected. Her breasts were lactating and nothing abnormal was observed. The vulva and perineal pad were inspected after permission was CVsought and lochia was red (rubra), flow was small and not offensive. She was reminded on changing of perineal pad frequently especially when soiled to prevent ascending infection to the uterus. Client then complained of after pain. She was reassured and educated that it was as a result of involution of the uterus. She was then encouraged to practice good personal hygiene and do warm sit bath to help reduce the pain. On palpation, the uterus was well contracted and symphysio fundal height was 17 centimetres.

Madam Doreen took fufu with light soup as her breakfast. She was educated to practice exclusive breastfeeding on demand especially in the night. Every two to four hours or at least 8 to 12 times per day, the baby should be breastfed. Client was educated on the importance of breast milk to both mother and baby such as to aid in bonding as well as exclusive at night to serve as a family planning method. Education on proper personal and environmental hygiene to prevent infections was reinforced. Client was also encouraged to take in a balanced diets.

She was encouraged to take enough rest, perform postnatal exercises and ambulate to help her abdominal muscles and pelvic floor muscles gain their tone. She was also reminded on how to

perform self-breast examination and educated on its importance. The in-charge was informed about the procedures and findings, client and baby were reassessed for confirmation. She was informed of her discharge and was helped to pack her things. Routine drugs were prescribed according to the protocol of the facility. She was told to come for one week postnatal care on the 17th November, 2021. She was informed about the continuity of care and that she would be visited at home for seven days to check on her condition and that of the baby. Her mother was encouraged to take good care of her and also provide her with physical, emotional, psychological and financial support. She was again educated on the prescribed drugs, its route, dosage and effects and encouraged to register the baby at the births and deaths registry. Client was asked if she had any other complaints or questions and she said no. She was discharged at 2:00pm on the 9th November, 2021.

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

Madam Doreen and her baby were visited on 10th November, 2021 in the evening at 7:00 am.

Both mother and baby looked healthy on arrival to their house. Greetings were exchanged with warm welcoming. She was informed of the procedures to be carried out. Hands were washed and dried. The baby was top and tailed after head to toe examination was done and no abnormality was detected. Baby passed meconium and urine during the procedure. The cord was also dressed with sterile cotton wool swabs and methylated spirit using aseptic technique, it was clean, dry and not offensive. The baby was dressed, wrapped and given to the client's mother. Madam Constance emptied her bladder and head to toe examination was done. The conjunctiva was examined and there was no pallor. The breasts were soft and lactating well. The uterus was well

contracted and symphysio fundal height was 16 centimetres. The perineum was clean, dry and intact, lochia was small, red and not offensive.

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

OBSERVATION	**VALUES**
Temperature	36.5^0c
Pulse	80bpm
Respiration	21cpm
Blood pressure	100/70mmHg
Uterus	17cm

The baby's vital signs and weight were also recorded as follows:

OBSERVATION	**VALUES**
Temperature	36.8^0c
Apex heart rate	124bpm
Respiration	40cpm
Weight	3.6kg
Skin Colour	Pink
Suckling	Yes

Baby was given to mother to breastfeed and baby was able to suckle well. Client was asked if she had any question or problem and she complained of not being able to sleeps. She was

reassured, encouraged to take naps in the afternoon and sleep whenever baby is asleep or whenever possible. Madam Doreen was educated on danger signs of the newborn such as breathing difficulties, cyanosis, persistent vomiting, fever, crying weakly, refusal of baby to feed and yellowing of the palms of the hands and soles of the feet. Client and family were congratulated and permission was sought to leave. She was informed of the next home visit the next day.

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

On 11^{th} November, 2021 at 7:00 am and 5:00 pm, Madam Doreen was visited twice to assess her and her baby. On observation, the general condition of the family was good. The procedures to be carried out were explained to her. The symphysio fundal height was 15centimeters.

The perineum was inspected and it was clean, dry and intact with small bright red lochia which was not offensive. Mother vital signs were checked and recorded as follows:

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.6^0c	36.5^0c
Pulse	76bpm	80bpm
Respiration	19cpm	20cpm
Blood pressure	90/60mmHg	100/60mmHg
Uterus	16cm	16cm

Permission was sought to top and tail and dress baby's cord but before that, head to toe. Baby was top and tailed and cord was dressed and left to dry. Baby was wrapped in a cot sheet and

given to mother for breastfeeding. Baby's vital signs and weight were checked and recorded as follows:

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.8^0c	36.7^0c
Apex heart rate	130bpm	132bpm
Respiration	38cpm	40cpm
Weight	3.6kg	3.6kg
Stool Colour	Yellowish	Yellowish
Suckling	Yes	Yes

During head to toe examination no abnormality was detected but on breast examination, client's breast was full on inspection and the breast was tender to touch on palpation. She was reassured and she was educated to breastfeed baby on demand to reduce the breast pain and can also lie on bed to breastfeed effectively. She was also educated on other positions that can be used during breastfeeding such as lying on her side.

Client and family were thanked for their cooperation and permission was sought to leave and return the following day.

THIRD DAY POSTNATAL HOME VISIT (4^{TH} DAY POST DELIVERY)

Madam Doreen was visited at home twice to check on how she and the baby were faring on 12^{th} November, 2021 at 7:00am and 5:00pm respectively. Greetings were exchanged and permission was sought to inspect her perineal pad. Her lochia was pink serosa and not offensive. Client said

the lower abdominal pain has stopped when asked. Client complained of nappy rash on the baby and she was encouraged to continuously changed baby's diaper when soiled. And also used cotton diapers. She also said she was able to have enough sleep now. Head to toe examination was conducted and everything was normal. The uterus was firmly contracted and symphysio fundal height measured 14 centimetres. Vital signs were checked and recorded as:

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.7^0c	36.5^0c
Pulse	88bpm	78bpm
Respiration	18cpm	19cpm
Blood pressure	100/60mmHg	100/60mmHg
Fundal Height	15cm	15cm

Mother was asked to top and tail the baby under supervision which she did very well with few lapses. Head to toe examination was done and everything was normal. Baby's cord was dressed with six cotton wool swabs and methylated spirit and left to dry. The cord was not offensive and the baby passed stools and urine in which stools were brownish yellow in colour.

The baby's vital signs and weight were checked and recorded as follows:

OBSERVATION	**MORNING**	**EVENING**
Temperature	36.5^0c	36.8^0c
Apex heart rate	136bpm	140bpm
Respiration	46cpm	45cpm

Weight	3.7kg	3.7kg
Condition of cord	Clean and dry	Clean and dry
Stool Colour	Dark yellow	Dark yellow
Suckling	Yes	Yes

Client was thanked for her cooperation and support. She was asked to take her routine drugs and permission was sought to leave.

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

Madam Doreen was visited again on 13^{th} November, 2021 at 7:00am. Mother, baby and family looked healthy on arrival. Client said she was relieved of her lower abdominal pain when she was asked about it. Head to toe examination of the baby was done and no abnormality was detected.

Baby's cord was dressed with methylated spirit, it was dry and non- offensive and the stump was almost off. Head to toe examination was carried out on the mother and result was healthy afterwards. On palpation, the uterus was well contracted and the symphysio fundal height was 14 centimetres, perineum was inspected for Lochia and the color was pink (serosa) and the flow was small not offensive. The breast was lactating well. Her vital signs were checked and recorded as follows:

OBSERVATION	**VALUES**
Temperature	35.0^{0}c
Pulse	76bpm

Respiration	21cpm
Blood pressure	100/60mmHg
Uterus	13cm

The baby's vital signs and weight were checked and recorded as follows:

OBSERVATION	**VALUES**
Temperature	36.8^0c
Apex heart beat	138bpm
Respiration	47cpm
Weight	3.8kg
Stool Colour	Dark yellow
Suckling	Yes

Client was asked of complaints and she responded she is doing very well. Mother was encouraged to ask questions. All findings were communicated to her and the necessary documentations were done. Client was thanked and permission was sought to leave.

4.8 FIFTH DAY POST NATAL HOME VISIT (6^{TH} DAY POST DELIVERY)

On the 14^{th} November, 2021, Madam Doreen was visited at 7:00am. Mother and baby looked healthy on arrival. Baby was bathed, head to toe examination was done and no abnormality was detected. The cord was off and the stump was dressed with cotton wool swab and methylated

spirit, it was dry and not offensive. Madam Doreen was also examined from head to toe and no abnormality was detected. On palpation, symphysio fundal height was 13cm. Perineum was clean and lochia was small and serosa in color and not offensive when inspected.

Madam Doreen's vital signs were checked and recorded as:

OBSERVATIONS	**VALUES**
Temperature	36.8^0c
Pulse	72bpm
Respiration	21cpm
Blood pressure	100/60mmHg
Uterus	Contracted

Baby's vital signs were checked and recorded as:

OBSERVATIONS	**VALUES**
Temperature	36.8^0c
Apex heart rate	138bpm
Respiration	40cpm
Weight	3.9kg
Uterus	Yes
Stool colour	Dark yellowish

Baby was given to mother to breastfeed and baby's suckling was good. Mother was encouraged to continue with breastfeeding. Client was thanked and permission was sought to leave.

4.9 SIXTH DAY POSTNATAL HOME VISIT (7^{TH} DAY POST DELIVERY)

On 15^{th} November, 2021, Client and baby were visited at 5:00pm. Mother and baby looked happy on arrival and the whole family was doing well. Procedures to be done were explained to Madam Doreen. Her permission was sought and she consented. Head to toe examination was done for the baby and the mother and no abnormality was detected. Her symphysio fundal height was measured and it was 11cm. The perineal pad was inspected and lochia was pink(serosa) and the flow was small no foul smell. Maternal vital signs were checked and recorded as follows:

OBSERVATIONS	**VALUES**
Temperature	36.7^0c
Pulse	78bpm
Respiration	20cpm
Blood pressure	100/70mmHg

The baby was top and tailed and the umbilical stump was cleaned with cotton wool swabs and methylated spirit. The cord stump was clean and dry with no offensive odour.

The baby looked healthy and active. His vital signs were checked and recorded as:

OBSERVATION	**VALUES**
Temperature	36.7^0c
Apex heart rate	130cpm
Respiration	38cpm
Weight	4.0kg

Madam Doreen was asked if she had any problem and she said no. Client was informed about the termination of visits on the seventh day and permission was sought to leave after a short interaction.

4.10 SEVENTH DAY POSTNATAL HOME VISIT (8^{TH} DAY POST DELIVERY)

On the 16^{th} November, 2021, at about 5:00pm, client was visited for the last time. Greetings were exchanged and a seat was offered. Baby and mother were doing well. Madam Doreen's mother bathed the baby under supervision and she did it perfectly after head to toe examination was done on both mother and baby and no abnormality was detected. The baby passed urine and stools during the bath. The colour of the stool was bright-yellow. The uterus was no more palpable on palpation. The perineal pad was inspected and the lochia was scanty and brownish red in colour. The cord stump was dressed with six cotton wool swabs and methylated spirit by Madam Doreen under supervision and she did it well. The cord stump was clean, dry and healed. Mother's vital signs were checked and recorded as follows:

OBSERVATIONS	VALUES
Temperature	36.6^0c
Pulse	76bpm
Respiration	19cpm
Blood pressure	120/60mmHg

The baby's vital signs were:

OBSERVATIONS	VALUES
Temperature	36.7^0c
Apex heart rate	134bpm
Respiration	40cpm
Weight	4.1kg
Suckling	Yes

Madam Doreen was encouraged to continue exclusive breastfeeding for six months, ensure personal and environmental hygiene as she always does. The importance of immunizing the baby against the preventable childhood diseases was also explained to her. She was reminded of her visit to the clinic on the following day. She was also reminded to come to the hospital early for circumcision of the baby. Madam Doreen and her family expressed their heartfelt gratitude. They were thanked for their cooperation and also making the work easier. Permission was sought to leave.

FIRST POST NATAL VISIT TO THE CLINIC

On 17th November, 2021, Madam Doreen and her baby came to the Clinic at 8:00 am. They were welcomed and offered a seat. Client and baby were looking healthy and they were nicely dressed in all white. The purpose of this visit was to maintain the physical, psychological and medical wellbeing of mother and baby and also to do further investigations to know the state of health of both mother and baby and also for the circumcision. Client was asked how she and her family were doing and she said they were fine. General observations were made on her mood and attitude towards baby and all were okay. All procedures to be carried out were explained to her and her consent was sought. She was asked to empty her bladder and a sample of urine was taken to test for glucose and protein and all tested negative.

Her vital signs and hemoglobin level were checked and recorded as:

OBSERVATIONS	**VALUES**
Temperature	36.3^0c
Pulse	72bpm
Respiration	20cpm
Blood pressure	100/60mmHg
Haemoglobin	12.8g/dl

Privacy was provided and madam Doreen was helped to undress and 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, the hair was very neat, well combed and clipped with white ribbon and free from lice and dirt. The conjunctiva was pink; there were no discharges

from the eyes, nose and ears. There was no abnormality detected in the mouth and there was the absence of enlarged lymph nodes around the neck. The breast was lactating well; there were no sore or cracked nipple and breast engorgement. The abdomen was firm; there was no tenderness, no scars, enlarged liver or spleen on examination. The uterus was not palpable.

There was no oedema, varicosities and tenderness in the calf muscle. The perineum was intact and there was no offensive vaginal discharge. The lochia was small and the color was alba. She was thanked for her cooperation and helped to dress up. The baby was also examined from head to toe and no abnormality was detected. The umbilical stump was inspected and it was healed. The baby looked healthy and active. The baby's vital signs were checked and recorded as follows:

OBSERVATIONS	**VALUES**
Temperature	36.6^0c
Apex heart rate	138bpm
Respiration	38cpm
Weight	3.6kg

Mother was encouraged to ask questions but she said there was none. Client was educated on exclusive breastfeeding and the importance of attending child welfare clinic. All findings were recorded and communicated to client.

CIRCUMCISION OF THE BABY

- After examination of the baby, Madam Doreen was informed that the circumcision is about to be done and asked if she want to observe but she replied no.

- The baby was prepared and circumcised by the midwife in-charge. Gel was applied to the circumcised area, wrapped with gauze after which baby was clothed and given to the mother to breastfeed him.
- Education was given to mother to wash hands with soap and water before handling baby and also to keep the wound dry to prevent it from infection and also report if bleeding, swelling and discharges

SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in charge, client reported to the clinic on Wednesday, 19/01/2022 with her baby and her mother at exactly 9:30am. Urine was taken and tested for sugar and protein and the result was negative.

Her vital signs were checked and recorded below:

Temperature	36.5 degree celsius
Pulse	82 beat per minute
Respiration	21 cycle per minute
Blood pressure	110 60 millimeters per mercury
Weight	63 kilogram

The baby was also examined from head to toe and nothing abnormal was detected. All findings were explained to the mother and recorded.

Vital signs checked and recorded below:

Temperature	36.7 degree celsius

Apex beat	135 beat per minute
Weight	4.0 kilograms
Respiration	36 cycles per minute

Baby was given due immunization at the child welfare clinic by the midwife in charge. The baby was immunized against pneumonia, Diphtheria, Pertusis, Tetanus, Hepatitis B, Heamophilus influenza B (5 in one vaccine).

The following vaccine were given:

Vaccine	**Dosage**	**Route of administration**
Polio 1	2 drops	oral
Rotavirus 1	1.5ml	oral
DPT -HepB Hib	0.5ml	intra- muscular,left thigh
Pneumococcal 1	0.5ml	intra- muscular,right thigh

Mother was encourage to practiced exclusive btreastfeeding to inhibit ovulation.The client was educated on family planning .She was advised to report any problem they may encounter to the nearest health facility. The client was then handed over to the public health nurse for continuity of care.

CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

Madam Doreen complained of:

- After pain (lower abdominal pain) on 10th November, 2021.
- Sleeplessness on 13th November, 2021.
- Breast engorgement on 11th November, 2021.
- Fatigue on 13th November, 2021

SHORT TERM OBJECTIVES

- Client will be relieved of after pain within 48 hours
- Client will be able to sleep for continues 2 hours within 24 hours
- Client will be relived of breast engorgement within 48 hours
- Client will be relieved of fatigue within 48 hours.

LONG TERM OBJECTIVES

Madam Doreen and her baby will have a safe and normal puerperium without any complications.

TABLE C: CARE PLAN DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/21 7:00am	Acute pain (after pain) related to involution of the uterus.	Client's after pain will reduce within 48 hours as evidenced by 1.Client verbalizing that her after pain has reduced 2. Midwife	1. Reassure client to allay fears and anxiety. 2. Explain the physiology of after pain to the client. 3. Advice client to breastfeed on demand 4.Ecourage client to empty her bladder frequently 5. Administer prescribe analgesic to reduce client after pain	1. Client was reassured to allay fears and anxiety. 2. Physiology of after pain was explained to the client. 3. Client breastfed baby at least eight times a day. 4. Client emptied her bladder frequently whenever she has the urge to. 5. 1g of paracetamol was administered to reduce client after pain.	12/11/21 6:00am	Goals fully met as 1. Client verbalized that her after pain has reduced. 2. Midwife observed client had a cheerful face.	A.D

		observing that client has a cheerful face.					

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDER	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
10/11/2021 8:00am	Inadequate sleep related to demand of feeding of baby at night.	Madam Doreen will be able to sleep for continue 2 hours during the day as evidenced by client reporting that she can now sleep well.	1. Reassure client to have warm bath to help have adequate sleep. 2. Encourage client's relatives to help her in the care of the baby during the day. 3. Encourage client to limit her time spent with visitors.	1. Client was reassured to take a warm bath to help her have adequate sleep. 2. Client's relatives were involved in daily activities to help client in the care of the baby for her to sleep during the day. 3. Time spent on visitors was limited for client to	12/11/2021 7:30am	Goal partially met as verbalized by client being able to sleep for continues two hours when baby sleeps at night.	A.D

			4. Encourage client to sleep in a noise free environment. 5. Encourage client to sleep whenever baby sleeps. 6. Encourage client to breastfeed baby well before going to sleep.	have enough rest. 4. Client was able to sleep well in a noise free environment. 5. Client was encouraged to sleep whenever baby sleeps. 6. Client was encouraged to breastfeed baby well before going to sleep.			

TABLE C: CARE PLAN DURING PUERPERIUM CONTINUE

DATE & TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE & TIME	EVALUATION	SIGN
13/11/21 8:00am	Breast engorgement related to inadequate emptying of the breast.	Client breast engorgement will be relieved within 48 hours as evidenced by 1. Client verbalizing that the breast is no more tender to touch 2. Midwife visualizing that the engorgement has been relieved.	1. Reassure client to allay fear and anxiety. 2. Teach client on how to fix baby correctly to the breast. 3. Teach client how to correctly position herself when breastfeeding 4. Encourage client to do manual expression of	1. Client was reassured to alley fear and anxiety. 2. Baby was fixed correctly to breast. 3. Demonstration was done to client on how to position baby during breastfeeding 4. Client expressed her breast milk manually.	15/11/21 6:30am	Goal fully met as 1. Client reported that her breast is no more tender to touch. Midwife observed that client had a relieved breast engorgement.	A.D

			breast milk when not feeding. 5. Encourage client to continue exclusive breastfeeding. 6. Encourage client to apply cold and warm compress to the breast.	5. Client continued exclusive breastfeeding. 6. Client applied cold and warm compress to the breast.			

PUERPERIUM CARE PLAN CONTINUED

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVE/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/TIME	EVALUATION	SIGN
13/11/21 7:35am	Fatigue related to stresses of labour.	Client will be relieved of fatigue within 48 hours as evidenced by; 1. Client verbalize she is relieved of fatigue.	1. Reassure client that her condition is temporal and can be managed. 2. Encourage client to have enough rest 3. Advise client to ensure noise free environment. 4. Advise client to have a warm bath before resting. 5. Encourage client support	1. Client was reassured that the fatigue is temporal and would be managed. 2. Client took rest when baby was asleep. 3.Client slept in a noise-free environment 4. Client took warm bath before resting.	14/11/21 8:30 am	Goal met as client reported that, she was relieved of body discomfort.	A.D

			person to help with the house hold chores.	5. Support person helped client With house hold chores.			

TERMINATION OF CARE

On 17th December, 2021, it was explained to Madam Doreen that the care being given to her by me has come to an end since the period of study was over. The day of postnatal visit to the clinic I reminded her that the routine home care will be terminated that day and then she would be handed over to the midwife in charge. Education on various topics which included, family planning, immunizations of her baby till the baby is five years old, registration of the baby at birth and death office and also to check on her nutrition. I also advise her to breastfeed exclusively for six month. Client was then handed over to the midwife in charge. She looked through her records I handed over and confirmed everything was normal and ensured me that, she will also hand her over to the community health nurse for continuity of care. It was made known to Madam Doreen that update on her will be received from the midwife in-charge. Client was encouraged again to report to the clinic immediately anytime she and her baby are not feeling well. I then encouraged her to have enough rest to gain her strength. Client was informed that she will be called if the need arises for any information, and she gladly said she will be available any time needed. She and her entire family were thanked for availing themselves and helping me to achieve this study. Madam Doreen expressed her gratitude for the care given to her. She and the family were bid farewell.

SUMMARY AND CONCLUSION

The Patient/Family Care Study has given an account of how the midwifery nursing process approach was used in nursing Madam Kunadu Doreen throughout pregnancy and after birth. Client is a native of Mpuasu in the Bono Region. A 27 years old gravida 3 para 2, who was an attendant at Green shield hospital for antenatal care, was chosen among the lot because she fell within the criteria for clients to be chosen for the care study. Friendship was then established to render effective care throughout pregnancy, labour and puerperium.

Home visit were done and the minor problems that were encountered during the period of pregnancy, labour and puerperium were all managed using the nursing process. Her successful antenatal care, labour and puerperium were due to the early assessment and analysis of her problems, proper counseling and education. She had a spontaneous vaginal delivery to a live male child on the 8th of November, 2021 at 3:05pm without any complications. The appropriate cares were rendered to her and the baby. She was also educated appropriately.

She had intensive puerperal care and all visits and examinations were carried out on her as required and hence she had a normal and safe puerperium. The baby also received all appropriate immunizations required at birth for the prevention of any diseases or complications. She was finally handed over to the midwife in charge for the continuity of care. There was proper and accurate documentation of all activities and procedures carried out on her and the baby for proper and easy reference.

The Client / Family Centered Care Study has enabled me to understand the unique essence of the case study and the midwifery profession as well as the managerial tool and step for managing any pregnant woman through antenatal, labour and puerperium and therefore sustained.

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APPENDIX 111

MOTHER'S ANTENATAL

DATE	WEIGHT (KG)	BLOOD PRESSUE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE(FH)	TREATMENT GIVEN	COMPLAIN	SIGN
9/06 /21	59kg	110/70mmHg	Negative/ Negative	16weeks	14cm	-	-	-	Routine drugs	Waist pain	R.A
14/07/21	60kg	100/70mmHg	Negative/ Negativ	20weeks	19cm	-	-	-	Routine drugs	No complain	R.A

			e								
11/08/21	63kg	110/80mmHg	Negative/ Negative	24weeks	23cm	-	-	-	Routine drugs	Constipation and Heartburns	E.O
8/09/21	65kg	110/70mmHg	Negative/ Negative	28weeks	26cm	-	-	135bpm	Routine drugs	Feels well	R.A
13/10/21	74kg	110/70mmHg	Negative/ Negative	32weeks	30cm	Cephalic	-	140bpm	Routine drugs 1G of paracetamol tid X7	No complian	R.A

DATE	WEIGHT (KG)	BLOOD PRESSUR	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
20/10/21	76kg	110/70mmHg	Negative / Negative	37weeks	36cm	Cephalic	$5/5^{th}$	140bpm	Routine drugs	Fatigue	A.D
27/10/21	77kg	100/70mmHg	Negative / Negative	38weeks	37cm	Cephalic	$5/5^{th}$	140bpm	Routine drugs	heartrburns and constipation	A.D

03/11/21	78kg	110/80mmHg	Negative / Negative	39weeks	38cm	Cephalic	$5/5^{th}$	137bpm	Routine drugs 1G of paracetamol tid X7	Waist pain and lower abdominal pain	A.D

PATOGRAPH

ITN GIVEN – 11/08/21

TETANUS IMMUNIZATION	PREVIOUS TT CURRENT TD 4th dose		TD 1 Yes TD 2 and TD 3 Date 19/07/20		No Date	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 9/06/21	Gestation age In weeks 16weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 14/07/21	Gestation age In weeks 20weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)11/08/21	Gestational age in weeks 24weeks
	4th dose 3 tabs (Direct observed therapy)8/9/21	Gestation age in weeks 28weeks	5th dose 3 tabs (Direct Observed Therapy)20/10/21	Gestation age in weeks 37 weeks		

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

MATERNITY CHART

APPENDIX I: COMPLETED DIAGNOSTIC INVESTIGATIONS
ANTENATAL

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS

COMPLETE DIAGNOSTIC INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
9/06/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
14/07/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

11/8/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal
8/09/21	1. Urine 2. Blood	Sugar Protein Haemoglobin Level	Negative Negative 12g/dl-16g/dl	Negative Negative 12.8g/dl	Normal Normal Normal
13/10/21	1. Urine	Sugar Protein	Negative Negative	Negative Negative	Normal Normal

DATE	SPECIMEN	INVESTIGATION	NORMAL VALUES	FINDINGS	REMARKS
27/10/21	1. Urine 2. Blood	Sugar Protein Haemoglobin	Negative Negative 12g/dl-16g/dl	Negative Negative 12.9g/dl	Normal Normal Normal
3/11/21	1. Urine 2. Blood	Sugar Protein Haemoglobin	Negative Negative 12g/dl-16g/dl	Negative Negative 12.8g/dl	Normal Normal Normal

APPENDIX II

PHARMACOLOGICAL DRUGS FOR MOTHER

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

Tablet Ferrous sulphate	Iron supplement	200 milligrams once daily	Orally	Helps in the formation of haemoglobin and red blood cell	Increased haemoglobin level	Gastrointestinal disturbances. Dark stools.	Dark stools
Tablet Metronidazole	Antibiotic	400 mg 3 times daily	Orally	Fights against bacterial infection	Fights against bacterial infection	Stomach pain, dizziness, dry mouth, cough, sore tongue	No side effect observed
Tablet Paracetamol	Analgesic and anti-pyretic	1 gram 3 times daily	Orally	Relieve pain and Reduce body temperature	Pain relieved	Prolonged use may cause liver damage.	No side effect observed.

Capsule Amoxicillin	Antibiotic	500mg 3 times daily	Orally	Fights against bacterial infection	Bacterial infection prevented	Nausea, stomach pain, diarrhoea, vomiting	No side effect observed.

PHARMACOLOGICAL DRUGS FOR MOTHER CONT'D

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

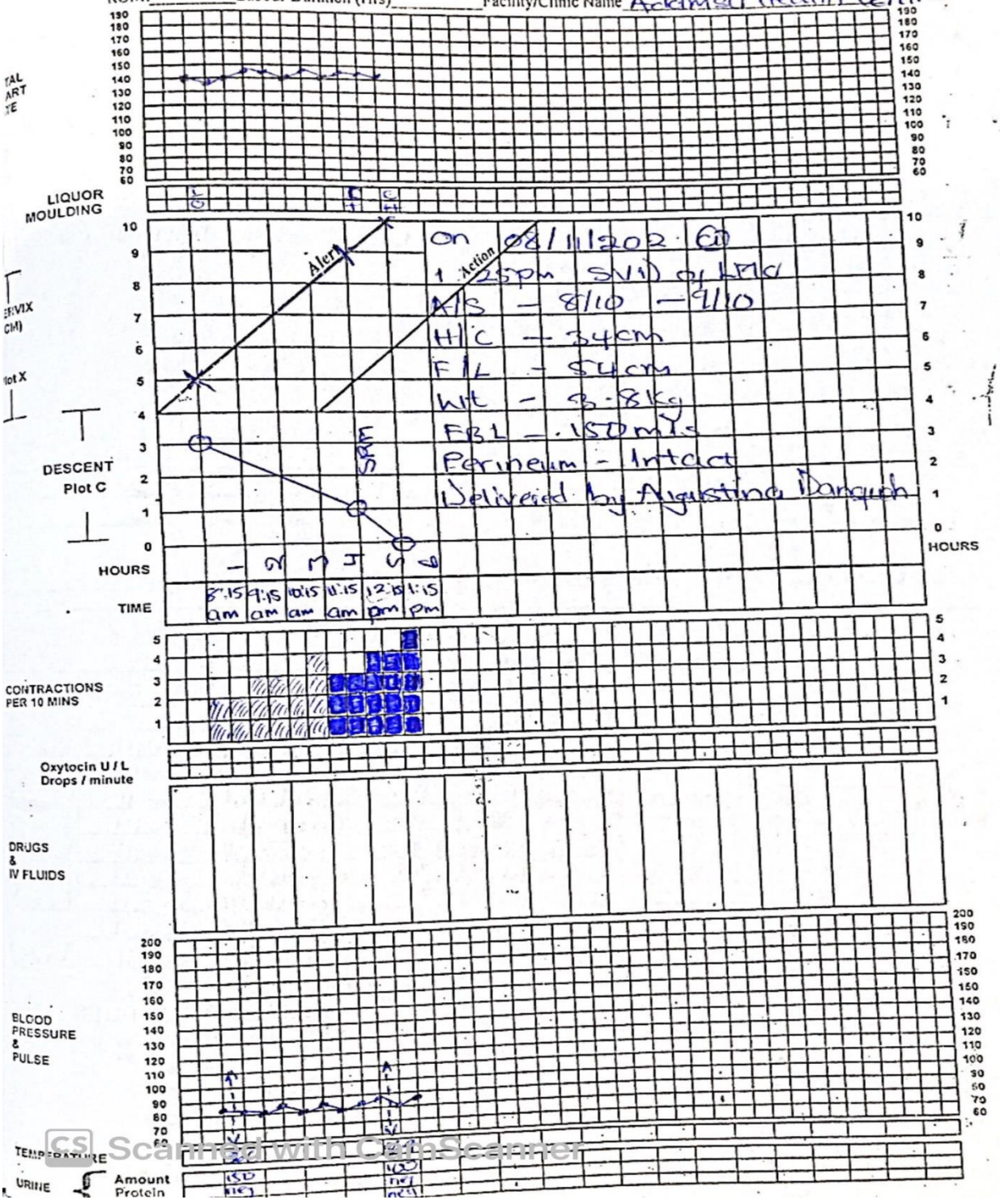
PHARMACOLOGICAL DRUGS FOR BABY

NAME OF DRUG	CLASSIFICATION	DOSAGE	ROUTE	USE AND ACTION	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Injection vitamin k	Coagulant (Group K Vitamins)	1.0mg	Intramuscular	Production of prothrombin which aids in clotting.	No bleeding	Risk of haemolysis in people with G6PD deficiency.	No side effects observed.
Chloramphenicol eye drop	Antibiotic	2 drops	Instillation	To prevent eye infection.	Eye infection was prevented.	Transient stinging	No side effect observed.
Oral polio vaccine	Antigen vaccine	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Poliomyelitis was prevented.	Diarrhoea Fever	observed.
Capsule vitamin	Group A vitamin	200,000	Orally	Growth, development	Normal vision	Vomiting	No side effect

A	supplement	units for 2 days		and proper sight	and healthy skin.		observed.
Injection Bacillus Chalmette Guerin (BCG)	Antigen vaccine	0.05 milligrams	Intradermal injection	Production of antibodies against tuberculosis	Still under observation	Blister formation and fever	Blister observed

WHO Modified Partograph

Registration No.: 0881/21 Name(Last, First) Konadu Doreen Age: 27 years
Date: 8/11/21 Parity/Gravida 2/3 LMP 102 EDD 9/11/21 Gestation(wks) 39 weeks
ROM: _____ Labour Duration (Hrs) _____ Facility/Clinic Name Ackamsu Health Centre



LABOR NOTES

Client of G3P2 with 39weeks gestation reported to the facility on 8/11/21 at 8:00am accompany by sister with complain of lower abdominal pain and appearance of sho[illegible] Abdominal examination was done and presentation was ceph, descent [illegible] lie longitudinal and on auscultation FHR = 140bpm. V/E was done and [illegible] was seen with membrane intact and no moulding. Education on [illegible] stages of labour was explained to her with reassurance. labour [illegible] well and client delivered spontaneously to LBC with B/wt = 3.8kg at 1:2[illegible] AS was 8/10 - 9/10 respectively. 3rd stage was completed by CCT at 1:30pm, EBL [illegible]

Please circle or write responses.

DELIVERY

DATE: 8/11/21 TIME: 1:25pm METHOD: (Spontaneous) / Vacuum Extraction / C/S / Other

PERINEUM: (Intact) / Episiotomy / Laceration

ANESTHESIA: (None) / Local / General

THIRD STAGE

Active Management: (Yes) / No Medication: Time 1:27pm Type/Dose 10units of Oxyto[illegible]

PLACENTA: TIME: 1:30pm Complete / Incomplete

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

BABY

Weight: 3.8kg

Sex: (Male) / Female

Baby Position: (Vertex) / Breech / Other

APGAR

Time	Color	Breath	Heart	Tone	Reflex	TOT[illegible]
1min	1	2	2	2	1	8/1[illegible]
5min	2	2	2	2	1	9/1[illegible]

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

	Frequency	Time	B/P.	Pulse	Fundus	Bleeding	Bladde[illegible]
FOURTH STAGE MONITORING	Every 15 minutes first 2 hours	1:35pm	110/60	86	18cm	Small	
		1:50pm	110/60	78	contracted	small	Empty
		2:05pm	110/70	82	contracted	Small	
		2:20pm	110/70	80	Contracted	Small	Empty
		2:35pm	110/60	80	Contracted	Small	
		2:50pm	110/70	79	Contracted	Small	Empty
		3:05pm	110/60	80	Contracted	Small	
		3:20pm	110/60	81	Contracted	Small	Empty
	Every 30 minutes For 1 hour	4:50pm	110/60	81	Contracted	Small	
		5:20pm	110/70	78	Contracted	Small	Empty

Birth Attendant Augustina Danquah (student midwife) Date 8/11/21

Assisted by Elizabeth Obubuafo (Midwife In-charge)

MATERNITY CHART

NAME: Konadu Doreen

AGE: 27 years WARD: Lying-In

IP NO.: 088/21 BED NO.:

Date	8/10/21	9/10/21	10/10/21	11/10/21	12/10/21	13/10/21	14/10/21	15/10/21	16/10/21
Days in Hospital	D1	D1	D2	D3	D4	D5	D6	D7	D8
Days P. O.									
Hour Am		8:30	7:30	8:00	8:10	7:30	8:00	7:30	8:40
Pm	1:25								

Temperature

C F

41.1° 106°F

40.5° 17CM

40.0° 16CM

39.4° 15CM

38.8° 14CM

38.3° 13CM

37.5° 12CM

37.0° 11CM

36.5° 98°

36.0° 97°

35.5° 96°

35.0° 95°

Symphysio Fundal height

Temperature

scale

2cm 1unit

Pulse

	80	76	80	76	76	76	72	78	76
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed
	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed	Passed

TEMPERATURE CHART

ME: Baby Kwadwo Konadu

E: Newborn WARD: Lying-In

O.: BED NO.:

Date	8/10/21	9/10/21	10/10/21	11/10/21	12/10/21	13/10/21	14/10/21	15/10/21	16/10/21
Days In Hospital	DD	D_1	D_2	D_3	D_4	D_5	D_6	D_7	D_8
Days P. O.									
Hour Am		8:30	7:30	8:00	8:10	7:30	8:00	7:30	8:40
Hour Pm	1:25								

Temperature

C F

Weight

Temperature

Scale

2cm : 1unit

Pulse

40 128 48 124 40 124 38 130 40 136 47 138 38 132 38 130 39 134

Passed Passed Passed Passed Passed Passed Passed Passed Passed

Passed Passed Passed Passed Passed Passed Passed Passed Passed

NEW BORN EXAMINATION FORM

Name: Baby Kwadwo Konadu Date of Assessment: 8/11/21 Time: 2

Date of Birth: 8/11/21 Time of Birth: 1:25pm Sex: ☑ M ☐ F Age at time of Assessment (days/hrs) 1

Astational Age ☐ 39wks ☑ Mode of Delivery: ☑ Vaginal Assisted Vaginal C-Section

APGAR: 1min 9/10 5min ☐ 9/10 Birth Weight: ☐ 3.8 kg ☐ Length: 54 cm Head Circumference: 34 cm

Temperature at time of Assessment: 36.8 °C Urine passed: Yes No Meconium passed: Yes

Name of Assessor (Midwife/Doctor): Augustina Sandiah (Student midwife)

1. Respiration
Rate 40cpm
- ☐ Rate < 30 b/m *
- ☐ Rate < 60 b/m *
- ☐ 30-60 b/m
- ☐ Retractions *
- ☐ Grunting *
- ☐ Stridor *

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

3. Tone
- ☑ Normal
- ☐ Floppy *
- ☐ Increased *

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

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

6. Cry
- ☑ Normal
- ☐ Shrill *
- ☐ Absent *

7. Suck
- ☑ Good
- ☐ Weak
- ☐ Absent

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

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

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

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

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

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

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

16. Clavicle
- ☑ Normal
- ☐ Swelling/Fracture

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

18. Heart rate
Rate: 128bpm
- ☐ Normal (100-160)
- ☐ <100 *
- ☐ >160*

19. Femoral pulse
- ☑ Present
- ☐ Not palpable*

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

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

22. Limbs
- ☑ Normal
- ☐ Abnormal _____

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

Female Genitalia
- ☐ Normal
- ☐ Fistula(meconium/uri through abnormal op vagina) *
- ☐ Large clitoria *
- ☐ Other: _____

24. Anus
- ☑ Patent
- ☐ Imperforate*

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

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

*May indicate severe disease that requires urgent referral

Diagnoses (if known) Normal baby

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

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

NEW BORN EXAMINATION FORM

ne: Baby Kwaduo Konadu Date of Assessment: 9/11/21 Time: 8:30am
e of Birth: 8/11/21 Time of Birth: 1:35pm Sex: ☑ M ☐ F Age at time of Assessment (days/hrs) 1day
tional Age ☐ ☐ Mode of Delivery: ☐ Vaginal Assisted Vaginal C-Section
GAR: 1min 8/10 5min 9/10 Birth Weight: ☐ 3·8kg ☐ Length: 54 cm Head Circumference: 34 cm
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42
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)-60 b/m
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runting *
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☐ Other:_____

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Male Genitalia
☑ Normal
☐ Undescended testes
☐ Abnormal meatus
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☐ Other: _____

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

24. Anus
☑ Patent
☐ Imperforate*

25. Resuscitation provided
☑ None
☐ Suction/stimulation
☐ Bag and mask
☐ Endotracheal Tube
☐ Ventilator/CPAP

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

indicate severe disease that requires urgent referral
oses (if known) Normal baby

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

NEW BORN CHART

Name: Baby Kwadwo Kanadu ..... No: ..... Birth Weight: 3.8kg .....

Sex: Male ..... Mother's No: 088/21 ..... Length: 54cm .....

Nature of Delivery: Spontaneous Vaginal delivery ..... Diagnosis: Term baby .....

Date of Birth: 8/11/2021 ..... Time: 2:25pm ..... Date of Discharge: 9/11/2021 .....

Date	8/11/21		9/11/21		10/11/21		11/11/21		12/11/21		13/11/21		14/11/21		15/11/21		16/11/21					
No. of Days	D0		D1		D2		D3		D4		D5		D6		D7		D8					
Weight	3.8kg		3.7kg		3.6kg		3.6kg		3.7kg		3.8kg		3.9kg		4.0kg		4.1kg					
Temperature	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM	AM	PM
		36.0°C	36.7°C		36.8°C	36.5°C	36.8°C	36.7°C	36.7°C	36.5°C	36.8°C		36.8°C			36.8°C	36.7°C					
Stools		Passed	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed			Passed	Passed					
Urine		Passed	Passed		Passed	Passed	Passed	Passed	Passed	Passed	Passed		Passed			Passed	Passed					
Remarks	Head Neck Trunck → NAD																					

SIGNATORIES

THE STUDENT MIDWIFE

NAME: AUGUSTINA DANQUAH

SIGNATURE: .....

DATE....28-09-2022.....

THE MIDWIFE IN-CHARGE

NAME: ELIZABETH OBUBUAFO

SIGNATURE: .....

DATE.....25-09-22.....

THE SUPERVISOR, (HOLY FAMILY NURSING AND NURSING TRAINING COLLEGE, BEREKUM)

NAME: MRS GRACE AFRIYIE KONAMA

SIGNATURE.....

DATE...03-10-2022.....

THE PRINCIPAL (HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE- BEREKUM)

NAME: MONICA NKRUMAH

SIGNATURE: .....

DATE ....04-10-2022.....

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