

Waikato Hospital

Name: Nurse L. Farguhar

Training as Student Nurse

Training begun: 11. 4. 60

Training finished: _____

FOR THE MATRON'S USE ONLY

I believe that the records in this book describe correctly the work done in this hospital by N. Farguhar and have all been written by her.

Date: 18. 3. 63 Signature: Adm. Hallam
Matron.

INSTRUCTIONS

NURSES AND MIDWIVES BOARD

All entries in this book are to be made by the pupil to whom it belongs, and, so far as possible, are to be written up daily. On the completion of her training it is to be signed below by the Matron.

Practical Experience in Obstetrics					Practical Work (Midwifery Trainees)				
The following table shows the minimum amount of practical work in the subjects mentioned required to be performed by each trainee:					The following table shows the minimum amount of practical work in the subjects mentioned required to be performed by each trainee:				
Subject	Class I		Class II	Class III	Subject	Class IV			
	1st Year	3rd Year							
Assistance at labour (a)		—	20	20	40	Assistance at labour (a)	.....	20	
Conduction of labour		—	5	5	10	Conduction of labour	.....	20	
Abdominal palpation—						Abdominal palpations—			
Ante-natal patient		5	10	15	30	Ante-natal patients	.....	20	
Labour patient		—	15	15	30	Labour patients	.....	20	
Rectal examination		5	15	20	40	Vaginal examinations	.....	20	
Ante-natal patients examined—						Rectal examinations	.....	30	
New patients		2	8	10	10	Ante-natal patients examined—			
Old patients		5	15	20	20	New patients	.....	20	
Labour patients prepared (a)		5	15	20	50	Old patients	.....	40	
Obstetrical anaesthetics		—	10	10	20	Labour patients prepared (a)	.....	20	
Puerperal patients nursed (a)		8	12	20	50	Obstetrical anaesthetics	.....	20	
Infants nursed (a)		8	12	20	50	Puerperal patients nursed (a)	.....	20	
Preparation of sterile dressings, appliances, etc., as prescribed in pamphlet H.—Mt. 20		—	4	4	10	Infants nursed (a)	.....	20	
Class I: Student nurse training under new Curriculum.						Catheterisations } as opportunity occurs.			
Class II: Registered nurse training as a maternity nurse.						Vaginal douches }			
Class III: Unregistered woman qualifying as a maternity nurse.						Preparation of sterile dressings, appliances, etc., as prescribed in pamphlet H.—Mt. 22	.....	6	
Class IV: Midwifery trainees.									

NOTE—(a) Two trainees may be given credit for assistance at the same labour, for the preparation of the same labour patient, for nursing the same lying-in patient, and the same infant. (b) Each trainee when nursing a lying-in woman shall also nurse her infant.

SCHEDULE

OBSTETRICAL CASE BOOK

Case Histories to be written as follows:

(1) MATERNITY TRAINEES (whether registered nurses or not) 10:

1 of which should be an Ante-natal case.

2 „ Infants (of which 1 if possible should be a premature):

3 „ Normal (to include both labour and puerperium):

4 „ Abnormal (1 abnormal labour and 1 complicated puerperium).

(2) STUDENT NURSES will now be required to write one record of the nursing of a normal mother and her baby during the first six weeks obstetrical experience.

(3) MIDWIVES—10—5 of the cases to be allocated as follows:

1 is to be a Normal case from the commencement of Pregnancy until discharge from hospital:

1 „ a Toxaemia of Pregnancy:

1 „ an Abnormal Puerperium:

1 „ an Abnormal Labour:

1 „ an Infant (a premature, if possible).

After the recording of each case the book shall be brought to the Matron or Sister in Charge, who shall examine and, if necessary, correct the entries made and help the trainee to keep her records correctly. Each trainee shall produce the book at her examination for inspection by the examiner, who shall take its contents into consideration when allotting his marks.

Normal Mother (Puerperium)

Mrs. L. E. B. To Anamulus Maternity Hospital.
Age 22 yrs. Parity: 5 Registered No. 10/177
Date and time of admission: 1.8.60 at 5.30 p.m.

Ante-natal health

Mrs. L. E. B. during her ante-natal period was keeping well and working and active housewife with home and farm duties. Her blood pressure and weight on attending clinic were satisfactory. She was given advice re diet, rest and exercise. She has been having movements. Mrs. L. E. B. has been attending a course of ante-natal exercises from a physiotherapist.

Labour and Delivery

Mrs. L. E. B. was admitted with history of contractions which were short and occurring at five minute intervals. The position of the foetus was L.O.A. with head engaged. The membranes ruptured at 3.15 a.m. and the cervix was fully dilated at 4.30 a.m. The duration of the labour was seven and a half hours. Normal labour and delivery of live female infant at 7.30 a.m. Third stage was normal and complete. Blood loss was estimated as four ounces. A small episiotomy was repaired with No 3 catgut sutures. The drugs administered during labour and following were Pitocin 100 mgms and Ergometrine with Hyaluronidase 5.5 mgms. After delivery of placenta patient was fully sponged and a binder applied. The patient was given a cup of tea and two biscuits and then allowed to rest for 10 hours in bed.

Nursing during Puerperium

Immediate Care

On transfer to her room Mrs. L. E. B.'s condition was that

of a tired but happy and contented mother. No relatives were given her to settle but she was given the opportunity to rest quietly in her room for four hours when the patient was transferred to her room. Her fundus was measured and was found to be a little bulky and about one inch above the umbilicus. The lochia was free and bright red but there was no copious blood loss. The patient was catheterized prior to delivery and the amount of urine passed at first passing was eighteen ounces were passed. Urinary output for first twenty four hours is measured and recorded. Mrs. L. E. B.'s temperature was 98° and pulse rate 88 at first reading in ward after delivery.

Subsequent Care

(a) Local. Mrs. L. E. B. had routine aseptic perineal toilet with normal saline four hourly and then the Infra-Red lamp applied to suture line for ten minutes each passing time for six days.

There are three essentials in the aseptic management of the puerperium and they are:-

- 1/ To prevent the entrance of bacteria into the vagina. Keep the raw surfaces be infected.
- 2/ To keep the vulva and perineum as dry as possible.
- 3/ To promote drainage from the uterus and vagina. Thereby removing the lochial discharges as quickly as possible.

The entrance of bacteria should be prevented by keeping the vulva and perineum as far as possible in a state of surgical cleanliness; by ensuring that all utensils and dressings used in the toilet of the vulva are sterile, that efficient antiseptic lotions are used

and the hands of the nurses are surgically clean; and by the intelligent use of suitable masks to prevent spray infection. The vulva and the perineum are kept dry by using dry sterilized dressings and by changing them every four hours so that the lochia discharge does not remain long in contact with the vulva.

The drainage of the uterus is promoted by turning the patient in such positions as favour the free flow of the lochia without allowing their accumulation in the uterus or vagina.

The patient is pinned and swabbed four hourly for the first four days and thereafter if she is not a suture case at 6.30 a.m. on the 5th, 6th, 7th and 8th days. The patient with sutures is swabbed four hourly until their removal.

The patient was fully groomed or bathed daily for the first three days and thereafter she may get up to the toilet and after the eighth day the bath.

The lochia was observed throughout the patient's confinement for colour, odour, and amount. Mrs. E.B.'s lochia was a little offensive on the seventh day and she was given Erythra tablets 4 times daily for twenty eight hours.

The puerperal patient is prone to infection because:-

- (a) There is a raw placenta site.
- (b) She has lost blood and this must be replaced.
- (c) She has sustained lacerations.
- (d) The lochia are alkaline, and favour bacterial growth.
- (e) She is tired and needs nourishment and fluids.

Special care was taken to suture area and the area was kept dry and clean. The infra-red lamp was applied for ten minutes, two to three feet away. The patient found this was drying and soothing. No key were non-soluble sutures and these were

removed on the fifth day and the area was treated. The area was then swabbed with normal saline and the lamp applied.

The fundus was measured daily at the 6.30 a.m. pinning and was recorded.

The various organs undergo a series of physiological changes which are known as the involution, on returning to their normal state.

At the end of labour the uterus is still a bulky organ about six or seven inches in length and by the end of the puerperium it is once more a normal small organ. This reduction can be noted by observation of the level of the fundus above the symphysis pubis. The patient's bladder must be empty before it is measured.

At the close of labour, the fundus is about half way between the symphysis pubis and the umbilicus. On the first day it is often high but thereafter the average rate of descent is about half an inch a day. By the eleventh or twelfth day, the fundus is usually below the pelvic brim and can hardly be palpated.

(b) General Care of the Patient.

+ Pulse and General Care.

A slight rise in temperature immediately post partum is not unusual. The pulse should not be raised. An increased pulse rate denotes stress or infection. Normally the temperature and pulse are taken one hour after delivery and thereafter twice daily. Should haemorrhage occur the pulse should be taken as frequently as the situation demands. If temperatures rise patient is on four hourly chart. Post Partum chills are to be avoided.

ii Rest and Sleep.

The nursing staff ensured that Mrs. L. E. B. was comfortable. First night she was given sedatives and thereafter as necessary. Mrs. L. E. B. had at least seven and half hours sleep at night and rest periods during the day. Sleeplessness must be reported.

iii Diet and Fluids.

3000 calories and high protein.

iv Hygiene.

Nurse full sponged Mrs. L. E. B. on first day and assisted with back etc.

v Anaemia.

Given ferrous sulphate gr 6 T.D.S. for iron, so as to prevent anaemia.

care of Breasts

Breasts are kept clean by scrubbing with sterile swabs and sterile water and drying carefully. Cracks are to be prevented. Oxeroin is applied if any sign of cracking, or else they are treated with Finic. Benz. Co.

Breast are supported by a binder which is finally applied by the nurse, after twenty four hours.

The nipples are kept clean and dry and prevented from becoming cracked excoriated.

Expressing helps to clear the ducts and thus give a more free flow of milk. When expressing, the nurse must be very gentle with the mother and expressing only on the areola and much damage is done to the tissues if a wider area is taken.

Mrs. L. E. B. was told that her hands must be clean and also her breasts she must be sitting comfortably

When feeding the baby the mother may lie on her side, sit up and lean forward or sit out of bed on a low stool. She must be at right with the baby's mouth so that the whole of the nipple and much of the areola is grasped. Baby should be gently handled at breast.

care of Bladder and Bowels.

The importance of regular micturition is that the fundus will return to normal more quickly. The bladder is often relaxed and there is little power to pass urine. The bladder must be emptied regularly, six to eight hours after delivery. Special care is taken in cases of extensive stitching. The quantity in twenty four hours passed was thirty four ounces.

Bowels: so much fluid has been lost either by the skin or kidneys and the milk that the bowels often become constipated. To prevent this a nursing mother should have at least three to four pints of fluid a day, two pints of which should be milk. When a patient becomes constipated the fundus remains high and consequently prevents the normal involution of the uterus.

Ambulation.

On the first day if the patient is feeling strong enough she is assisted with sponging in bed and is up for bed making. As Mrs. L. E. B. had sutures she remained in bed the first day and on the second day was up and sitting on stool for bed making. On third day she was walking round room. On fourth and subsequent days, Mrs. L. E. B. was walking along corridor and moving round more freely. From seventh day on she was fully ambulatory and up and attending own baby in nursery.

Mrs. L.E.B. co-operated and lay prone position for twenty minutes after the 10am and 3pm panning and version of uterus. The main reason for early ambulation is that it promotes quicker drainage of the uterus, promotes quicker restoration of muscle tone and prevent venous thrombosis.

Rest

Mrs. L.E.B. was encouraged to at least seven and a half hours sleep every night plus rest periods during the day. She was encouraged to rest at 11am and before visiting hours. At night quietness is observed by the nursing staff so as not to disturb the patients, and the baby is fed in nursery during night so as not to disturb the mother.

The value of rest as a nursing mother is that she will need good health on return home.

Diet.

A nursing mother needs 3000 calories per day of high protein diet and plenty of fluids - at least 3-4 pints per day. Mrs. L.E.B. immediately after labour was given a hot cup of tea and some biscuits. A jug of fluid is placed on the table. The meals in hospital are well planned and balanced and the nursing mother should continue her cooking on the same lines on return home. A well balanced diet should include fruit and vegetables, milk, eggs, wholemeal bread, fish and a moderate amount of meat.

Drugs and Prescriptions Used.

Pethidin 100 mgms. given at 12 mid night and 2.30am. for pain relief.

Ergometrine 0.5 mgms with Hyaluronidase given after

the expulsion of the placenta for the prevention or control of post-partum haemorrhage.

Ergotrate tabs T.T.D.S. for 48 hours given to expel any ragged membranes which still might be lodged in the uterus.

Ferrous sulphate tablets T.T.D.S. given for 48 hours to prevent anaemia, or if post-partum haemorrhage occurs.

Multivitamin tabs T.T.D.S. also given for 48 hours so as to build up the vitamins once more to normal.

Agarol, given for constipation, dosage - one tablespoon T.D.S.

Personal Hygiene. Mrs. L.E.B. was fully sponged after delivery and on ^{first} second day and on sixth and seventh day she was able to have a shower and a bath on the eighth, the patient is in clean clothing and keeps herself clean and fresh by having a good full sponge up until the sixth day and then by daily having a shower or bath. Her hands must always be scrupulously clean if she is to handle the baby or her breast which could easily become infected.

On admission the patient's bed is freshly aired and made and clean bed linen on. On the sixth morning the bed linen is changed or beforehand if it has become blood stained or soiled.

Prevention of Cross Infection.

Every morning each room is vacuum cleaned out and dusted and tidied. During the summer when there are flies present, sprays are used to

aid them.

Visitors are restricted to a certain extent to intimate relatives so as not to spread cross infection to the nursing staff and caring for the nursing mother and her baby. They must be free from infection and keep in a good state of health and cleanliness.

Back bedroom well ventilated and arranged to catch the sunlight well.

The temperatures are taken twice daily as an indication of any onset of infection.

Mothercraft On the seventh day Mrs. G. E. B's baby was transferred to the second nursery where it remains until discharge. In this nursery she was taught the important details about handling her baby and was shown how to bath and dress her baby and how to tuck her down. As a primipara Mrs. G. E. B. gained confidence by being shown and then allowed to change and tuck down baby at feed time. The baby's nappies were changed and the buttocks sponged when necessary and the buttocks sponged and cream applied if inflamed. In order that the baby had no undue handling the minimum of clothing should be worn. Usually a cotton singlet, nightgown, nappies and wrap. Baby was weighed every third day by the mother and before discharge.

Once or twice during the feeding of baby and at the end baby's back should be gently rubbed to help it upset wind. Mrs. G. E. B. was shown this by the nurse. Directly baby has expelled wind Mrs. G. E. B. saw that her baby was warm and dry and placed her in her cot. She was told that baby must not be handled unduly after a feed, otherwise it may upset it up.

Psychological Attitude

Mrs. G. E. B. was a little tired but supremely happy and contented with her new baby.

The staff were gentle and kind through her labours and showed interest in her and her baby when Mrs. B. required a nurse to assist her to express the nurse went willingly and tried to be helpful and as gentle as she could.

As Mrs. G. E. B. had intakes the staff were gentle and understanding while swabbing her and general be patient and tactful in conversation, by being cheerful but not boisterous.

An important feature of Mrs. G. E. B's confinement was the bright clean and cheerful hospital atmosphere, so that she felt contented also.

Advice given on discharge.

Mrs. B. was advised to take care for her own health so that she will keep well and continue to breast feed. She was also told that she must keep her breasts clean, and continue to expressing after feeding baby so as to prevent engorgement. About six weeks after discharge Mrs. G. E. B. was advised to see her own doctor so that he can ascertain whether the uterus is returning to normal or not, and also to make an appointment with the District nurse.

Mrs. G. E. B. and her baby daughter were both discharged in a satisfactory condition on their eleventh day.

Warner
Hedderman
Hos. Patient
28-8-60

Normal Baby.

Mother's initials: Mrs. F. B.

Register Number: 60/177

Type of Delivery: Normal.

Date and time of birth: 2/8/60 at 4:30 a.m.

Immediate Care

A baby has a low resistance to infection so the first care is related to preventing infection. This includes the eyes being wiped with a dry sterile swab as soon as it is born. Immediately at birth the baby is held upside down by his feet so as to drain by gravity any mucus in the air passages, or the mucus is extracted by means of a tube, with a special machine attached the air passages are now aspirated. The baby lies on sterile sheet on his back or side over his mother's leg. The cord is now attended to, it is clamped two inches from the umbilicus and again one inch further on. A cord tie is put on nearest the baby. The cord is now cut between the two clamps with a special cord scissors. The cord end near the baby is rubbed with tincture of iodine. A special cord clamp now replaces the first clamp and the baby is received in a sterile napkin and wrapped in warmed outer wrap and placed on his side with head left side or his right side. The temperature of the delivery is between 70 and 80 degrees. The baby is checked for any peculiar abnormalities.

Nursing Care. (1) Immediate

After mother had seen her baby she was taken to the nursery where the initial bath was performed.

Baby was washed with 2% phenol soap and her face was washed without soap and the rest of the baby wiped. It was then immersed in water which was approximately

100°F. The baby was then checked for abnormalities and it was found to be a normal healthy baby. Baby was then weighed and the birth weight was 6.5 pounds. The cord was treated by swabbing with methylated spirits and the clamp was removed, and a cord tie put on where the clamp was.

To prevent chilling the baby's clothing was laid out ready and all doors and windows were closed. The baby was kept as warm as possible during the initial period.

Baby's name was written on adhesive tape and placed on both soles of feet.

A small pink card was attached to the head of the cot with baby's name, date, time, doctor and weight.

A small Haseline bulldock square was placed on baby's buttocks so as to prevent meconium adhering to the napskin. Mobicutane plastic spray was used for ease.

The baby colour was a normal pink and breathing was established satisfactorily. The cord was tied and swabbed with methylated spirits. Baby went to breast the short while but seemed uninterested so given one ounce of boiled water, and it did not vomit. Baby passed urine and meconium after first feed. The baby was placed on its right side morning, noon, night and on its left side other times.

Subsequent Nursing Care.

Feeding. Times that baby B. was at breast.

1st Day 8 hourly feeding 3 min each breast. 1g p.c. B.H.

2nd day 4 hourly feeding 3 min each breast 1g B.H.p.c.

3rd day 4 hourly feeding 5 min each breast. No water.

4th day 4 hourly feeding 7 min each breast.

5th day continued hourly feeding 10 min each breast. Alternate breasts were offered each feed.

On 3rd day at that weight baby obtained one and half ounces. Baby B. was breast fed and nurse changed the G.C. to correct management of the babe at the breast.

Baby's wind was brought up every few minutes and at end of feed by gently rubbing baby's back.

Hygiene and Prevention of Cross Infection

When baby was sponged or bathed, her own, some equipment for example, soap and container, the clothes which the baby wore clean and the nurses made sure that articles of clothing as linen the baby might be in contact with was handled carefully and not dropped on the floor.

Nurse washes her hands thoroughly between bathing each baby and when bathing babe, takes particular attention to dry her thoroughly.

Baby's cot was kept aired each day and made up again with dry-bath clothing.

After twenty-four hours baby's cord was tied across the umbilicus and cut about an inch from the umbilicus and painted with tincture of Benzoin. Daily care then consisted of painting with methylated spirits until cord separated on seventh day. The cord must be free from infection and dry as umbilical infection can be serious and a moist base is one of the first signs of infection. An offensive cord and delay in separation are also due to infection. The nurses attending the baby also wash their hands before attending to baby's case.

Nurses' hands should be well cared for with nails cut short and cuticles well cared for.

Before coming on duty the hands should be scrubbed with soft nail brush in hot soapy water, then dried thoroughly and an antiseptic cream applied.

on entering the nursery and between each baby nurse, always washes her hands with an approved hand soap and applies antiseptic cream.

Masks should be properly worn to protect mother and baby from droplet infections. No nurse with upper respiratory infection attends any baby in the nursery.

Masks must not be worn more than half an hour or touched by the hands which causes the danger of infection from attendant to patient.

The hands should be washed after removing masks.

The nursery is kept clean by regular vacuum cleaning and polishing and dusting of nursery. It should be well ventilated and at a moderate temperature.

Observation of Progress

Baby B's micturition was always satisfactory but her bowel motions on the 5th and 6th day were green, which resulted because baby was receiving more than sufficient. Baby B. cried when it was hungry but was contented after feeds.

Baby's weight dropped two ounces from birth weight then she increased again until on the day of discharge she was four pound baby than her birth weight.

Baby had no skin eruptions but she had rather a sticky eye on her second day. Gargolisan drops were applied and it soon became normal.

Rest and Sleep

When Baby was tucked down she was carefully handled and made sure that all wind had been expelled. After feeding baby's nappies were changed and she was tucked down in the cot. The room was kept at a suitable temperature.

To prevent over tiredness baby was handled carefully and lightly but gently. Baby slept for most of the time. Between feeds, and this was ensured by the nurses so that she could sleep by keeping quiet in the nursery and making sure that she is warm.

Mothercraft.

When handled by her mother baby felt secure as the mother was less hurried than the nursing staff and more time to love and care for it. A baby who is handled by its own mother gets to know her not like in a nursery where a baby might be fed by a different nurse each feed. Mother also became confident in handling her own baby and there is less risk of infection to baby if handled by mother.

Discharge.

Baby B was discharge with her proud mother on the eleventh day and there was no obvious skin rashes and the skin folds were clean. The umbilicus was dry and Red, baby's fingernails prior to discharge were satisfactory.

Baby needs fresh air and exercise, sleep, rest, cleanliness, motherly and wise management. In addition baby requires a happy home where these needs can be supplied, where she can grow up and be a joy to her parents.

Baby B's weight on discharge was six pounds, seven ounces. Mrs. G.P.B. was instructed to notify her Plunkett nurse for further guidance and advice.

Enhanced
Jedwamun
28.8.60

A. Premature Baby.

Name: Baby M.

Date of Birth: 30. 12. 62.

Time of Birth: 8.32 pm.

Sex: Male.

Period of Gestation: 34 weeks.

Hospital Number: 62/1717.

Definition of a Premature Baby.

A baby weighing $5\frac{1}{2}$ pounds or less regardless of the period of gestation.

Causes of Prematurity:

Serious:—Eclampsia and Aneuplasm Haemorrhage.

Common:—Pre-eclampsia and twins.

Less common:—Fetal malformations; Hydramnios; Maternal gonorrhea; Acute infection; Emotional upset; Poor Economic Status.

In 50 per cent of cases no cause is apparent.

Signs of Prematurity:

- 1) Length - 18 inches or less.
- 2) Weight - $5\frac{1}{2}$ pounds or less.
- 3) Fontanelles and sutures are wide.
- 4) Pinna of ears are soft and flat.
- 5) Skull bones are soft.
- 6) Short, undeveloped finger and toenails.
- 7) Skin is red, loose and wrinkled due to lack of subcutaneous fat.
- 8) Lanugo is usually plentiful.
- 9) Eyes are generally closed.
- 10) The vernix is scanty.

Management of Labour.

A premature baby is ideally born in a warm room (75°-80°) with a warmed premature cot prepared in advance. The baby's mother would have been given analgesia and sedative drugs with care. Suction apparatus, stimulants and oxygen would be checked in readiness.

Baby M's mother had a rapid delivery in the labour ward and as soon as his respirations were established and his cord cut he was immediately placed in his cot and transferred to the premature unit of the nursery.

Care at Birth.

Immediately after birth baby M was suctioned with the wall suction and respirations were established. His umbilical cord was clamped and cut and he was placed in his warmed cot.

After Baby M. was transferred to the premature nursery he was left to rest for an hour and observed closely. By this time Baby M's respirations were regular and he showed no signs of requiring oxygen.

His initial toilet was now carried out and he was sponged carefully and his cord treated as usual. He was inspected but no abnormalities were detected. By this time his bowels had moved but he had not passed urine. Baby M's weight was 4 pounds 10 ounces.

Baby M's identification cards and records were made and he was placed back in the premature nursery. His colour was good so no oxygen was required.

Maintenance of Body Temperature.

Baby M was transferred immediately after birth to the premature nursery. This is a special room which is kept at a temperature of 90°-94°F and

with a humidity of 65%. In this room Baby M. lay in a lined cot and the only clothes he had on was a small lint napkin. In this way his body temperature was maintained. It was checked by taking his temperature every three hours.

When he was transferred to the weakling nursery Baby M. was dressed in a cotton singlet and ordinary napkins. He was wrapped in a cotton wrap and tucked down in the same cot that he had been in, in the premature nursery. For several days Baby M's temperature was taken before each feed and hot water bottles were placed in his cot if his temperature was low. As his temperature remained stabilised it was taken less frequently until it was discontinued.

The nursery was kept warm and at an even temperature also, and while being washed Baby M. was exposed as little as possible. In these ways Baby's body temperature was maintained.

Conservation of Body Energy.

To conserve Baby M's body energy he was cared for in his cot and only taken out to be weighed and for his initial toilet, during the first week. He was handled as little as possible and each day his face and buttocks only were washed unless he was to be weighed, and then he was sponged in his cot. His initial toilet was left until his condition was satisfactory and it was done quickly and gently.

All treatments ordered for Baby M. were carried out at the same time i.e. each feed time.

Overbreathing can also cause loss of body energy so this was prevented by taking his temperature regularly and adjusting his conditions according to the results.

Baby M. was fed by tube for a week to help conserve body energy.

Baby's clothes were easily managed so that he did not need to be handled a great deal when they were changed.

Prevention of Atelectasis:

Atelectasis is imperfect expansion of lung tissue due to obstruction in an airway. This was prevented in Baby M. by the following methods:-

- 1) Clearing of airway immediately after birth with suction and any other times as necessary.
- 2) By keeping Baby's clothes lightly and not tight to give room for expansion of lungs.
- 3) By changing Baby's position from one side to the other at each feed.
- 4) By giving Baby M. oxygen as required.

Feeding:

For the first week of his life Baby M. was tube fed in the nursery. On the eighth day baby was bottle fed & at every other feed and tube at other times.

Baby M. lost five ounces over the first few days but he quickly picked up weight again.

He was put onto six feeds a day so as he would gain weight more quickly. For the

first two weeks Baby's mother expressed her milk so that baby would not be deprived of natural food.

Following is a chart showing the feeding routine of Baby M.:-

Day	No. of feeds	Frequency	Method	Amount	Food Used
1st.	On Necessary	9am-5pm-8pm	Tube	1 ounce each	K'lac Sol.
2nd.	5	4 hourly	Tube	1 oz each feed	Breast Milk 1/2 oz K'lac Sol. 1/2 oz
3rd.	5	4 hourly	Tube	1 1/2 oz "	Breast Milk 1/2 oz K'lac Sol. 1/2 oz
4th.	6	4 hourly	Tube	1 1/2 oz "	Breast Milk 1/2 oz K'lac Sol. 1/2 oz
5th.	6	4 hourly	Bottle+tube	1 1/2 oz "	B.B.M. 1/2 oz
6th.	6	4 hourly	Bottle+tube	1 1/2 oz "	B.B.M. 1 1/2 oz
7th.	6	4 hourly	Bottle	2 oz "	B.B.Milk
8th.	6	4 hourly	Bottle	2 1/2 oz "	B.B.Milk
9th.	6	4 hourly	Bottle	2 1/2 oz "	Breast Milk 1/2 oz Milk mixture 2 1/2 oz
10th.	6	4 hourly	Bottle	2 oz "	Milk mixture 2 oz
11th.	6	4 hourly	Bottle	2 1/4 oz "	" " "
12th.	6	4 hourly	Bottle	2 1/4 oz "	" " "
13th.	6	4 hourly	Bottle	2 1/4 oz "	" " "
14th.	6	4 hourly	Bottle	2 1/2 oz "	" " "
15th.	6	4 hourly	Bottle	2 1/2 oz "	" " "
16th.	6	4 hourly	Bottle	2 1/2 oz "	" " "
17th.	6	4 hourly	Bottle	2 1/2 oz "	" " "
18th.	6	4 hourly	Bottle	2 1/2 oz "	" " "
19th.	6	4 hourly	Bottle	3 1/4 oz "	" " "
20th.	6	4 hourly	Bottle	3 1/4 oz "	" " "
21st.	6	4 hourly	Bottle	3 1/2 oz "	" " "
22nd.	6	4 hourly	Bottle	3 1/2 oz "	" " "
23rd.	6	4 hourly	Bottle	3 1/2 oz "	Milk mixture No 2 2-5 oz
24th.	6	4 hourly	Bottle	3 1/2 oz "	Milk mixture No 2 2-5 oz
25th.	6	4 hourly	Bottle	3 1/2 oz "	Milk mixture No 2 2-5 oz
26th -	6	4 hourly	Bottle	3 1/2 oz "	Milk mixture No 3 3-5 oz

until discharge.

Baby M. was on milk mixture No 3 $3\frac{1}{2}$ ounces at five feeds at the time of his discharge. He was also having Atkarsal mixture 2. Three times a day in his bottle.
Records:

The following records were kept of Baby M. 3 days or 4 hours according to his feeding times, until they were able to be discontinued when he was satisfactory. Weight (see chart Page 54) Baby M. after his initial weight loss, he gained adequate weight.

Food: Amount, time, method of feeding material as above and leftovers (anything left in the bottle.)

Vomitus: A record of anything baby vomited.

Urine and Bowels: Record of bowel motions and amount of urine passed especially in the first few days.

Body Temperature: Recorded as necessary.

Room Temperature: While in premature nursery.

Any hot water bottles in position.

Treatments or any drugs given: The only drug given to Baby M. was Vitamin K which was given on his first day. This is given routinely to premature babies to increase the clotting power of their blood.

Baby M's bowel motions and urinary output were satisfactory.

Prevention of Infection.

The following are ways in which infection was prevented in Baby M.

- 1) Swabbing of the eyes at birth.
- 2) Aspiration of airways at birth.
- 3) Cord care - end swabbed with iodine when cut. Sterilized on 2nd day and treated daily

- with Lincaine of Bengain until it separated.
- 4) General cleanliness of nursery and of equipment.
 - 5) Attendants free of infection and the use of a gown and mask at all times.
 - 6) Cleanliness of the skin.

Throughout his stay in the nursery Baby M. did not develop any infections.

Observations:

For the first few hours of his life Baby M. was watched closely to detect any changes until his condition was noticed to be quite satisfactory.

The following are points to observe when watching a Premature Baby:-

- 1) Change of colour which could indicate insufficient oxygen.
- 2) Rate and degree of respirations.
- 3) Keeping airways clear.
- 4) Oxygen - if required knowing at the correct amount.
- 5) Relaxation of feet and eagerness for some.
- 6) Any infections that could have occurred.
- 7) Conditions of buttocks and umbilicus.
- 8) General behaviour and amount of movement.
- 9) Bowels and urinary action.

Baby M's condition remained satisfactory and he progressed well. He was a hungry babe and ready for all his feed, and slept well between his feeds.

Getting to Normal State.

For the first 10 days premature care and records for Baby M. On transfer to the weaning nursery

he was given suckling care. This meant that he was given a full sponge or bath only on weigh days and he was fed in his cot for 11 days.

By the 16th day Baby M. was satisfactory in all respects but he still had to gain more weight before he could go home.

Baby M. was gradually introduced to normal care and his mother after her discharge came up once a day to see her baby and to feed and care for him.

Complications:

The only complication Baby M. suffered was very slight jaundice; however this decreased rapidly and by the time Baby was ready for discharge no signs of jaundice were present.

Discharge:

Baby M. was discharged in a satisfactory condition; his weight being 5 pounds 6 ounces on his 30th day. Mrs M. was given instruction on caring for her baby such as keeping him warm and free from draughts.

Temperature and Weight charts appear on Pages 52 and 54.

Dr. G. S. Sanders

G. S. Sanders

11. 2. 63.

A Normal Labour.

Definition of Labour (normal.)

Labour is the process by which the foetus, placenta and membranes are expelled from the birth canal after the 28th week of pregnancy.

Stages of Labour

1. First Stage - from the commencement of contractions to the full dilatation of the os. Frequently but not always this coincides with the rupture of membranes. The average length is 10-12 hours.

2. Second Stage - from the full dilatation of the os to the birth of the baby. Up to 2 hours in a primipara and 1 hour in a multipara.

3. Third Stage - This covers the period from the birth of the child to the expulsion of the placenta.

Name: Mrs K.

Age: 27 years.

No of Pregnancy: 6th.

Period of Gestation: 40 weeks.

Hospital No. 62/2147.

Ante Natal History

Signs of Onset of Labour

Abdominal examination will demonstrate periodic contractions of the uterus corresponding to the pains. On auscultation the foetal heart is heard with greater frequency during contractions, may be noted to be slower. Inspection may reveal a mucous discharge, and sometimes the os is effaced and intact.

contraction became too strong and from then on she rested between them as much as possible. Adequate rest and sleep is most essential especially if the labour is a long one.

Mrs K's bed was kept tidy and comfortable and reassurance and assistance was given by the nursing staff. A nurse stayed with Mrs K. as much as possible.

Elimination. Mrs K. was encouraged to empty her bladder every two hours. If she hadn't, it might have been necessary to catheterise her as a full bladder can delay labour. However Mrs K's urinary output was sufficient during labour.

On admission Mrs K. was given and her bowels moved again at 3.30 am.

Diet and fluids. Mrs K. was encouraged to drink plenty of glucose fluids with which she was supplied, and she also had other drinks such as tea so she rested.

If an adequate intake of fluids and food is not maintained during labour, acidosis will occur and produce vomiting. Acidosis in the urine will indicate depletion of glucose. This may lead to a state when the patient becomes dehydrated, shocked and exhausted.

Mrs K. however, had a good food and fluid intake during labour.

2. Pain Relief:

During the early stages of her labour Mrs K. was not unduly distressed by

1. 55 pm on the 31st she required some pain relief so was given Pethidine 100 mg by intramuscular injection.

Relief of pain was also gained by Mrs K. by keeping her comfortable and giving her reassurance as her labour progressed.

3) Observations:

Throughout labour the following observations were carried out and recorded fully and as necessary otherwise.

- a) uterine action - length, strength and frequency of contractions.
- b) Dilation of os and condition of cervix by rectal examinations.
- c) Any vaginal discharges.
- d) Advance of presenting part - abdominal and rectal examinations.
- e) Maternal conditions - general signs and by taking of the temperature, pulse and blood pressure and looking more every eight hours or more often if any abnormal constituents are present.
- f) Condition of the foetus by regular count of the foetal heart beat.
- g) Complications - anything abnormal that occurs in the above.

Results of observations are in the chart which appears on the following page:-

21. 1. 63.	Fetal Heart.	Mother's Pulse.	Intake	Output	Stools.	Length	Contractions. Type	Frequency, Drugs etc.	
2.30am	148	86	—	3ozs	Enema	1 min.	Nil.	Fair.	
3.30am	146	86	6ozs.	2ozs.	—	1 min	8-10 mins	Fair.	
4.30am	148	84	6ozs	8ozs.	—	$\frac{1}{2}$ min.	7-10 mins	Mild.	
6.0am	148	88	6ozs	—	—	$\frac{1}{2}$ -1 min.	8-9 mins	Mild.	
7.30am	146	80	3ozs	—	—	1 min.	8-9 mins.	Moderate	
8.45am	144	86	4ozs	—	—	1 min.	8-9 mins	Stronger.	
10 pm	Regular.	88	6ozs.	2ozs	—	$\frac{1}{2}$ -1 min	8 mins.	Stronger.	
11.15pm	138	90	2ozs	—	—	1 min	6 mins	Stronger	
12.30pm	134	86	6ozs	8ozs	—	1 min	5-8 mins	Strong.	
1.30pm	136	84	4ozs	—	—	$\frac{1}{2}$ min	3-5 mins	Strong.	Pethidine 10mg.
2.30pm	128	84	1ozs	—	—	$\frac{1}{2}$ min	5 mins.	Strong.	
3.30pm	132	88	3ozs.	4ozs	BO	$\frac{1}{2}$ min	3 mins.	Strong.	

Rectal Examination:

2.30 am. - Presenting part one finger length away, cervix soft and moderately thick. 1-2 fingers dilated.

4 pm - Presenting part $\frac{1}{2}$ finger length away - as $\frac{1}{2}$ - $\frac{3}{4}$ dilated.

Nothing abnormal occurred during the labour and she progressed to a normal delivery.

4) Management of Second Stage:

The R. progressed well in labour and she was fully dilated at 4.35 pm, half an hour before this Mrs K had been taken from the labour ward on a trolley to theatre, where she was to be delivered, and prepared for delivery.

1) General Care:

When she was on the theatre table Mr K lay in the left lateral position with her buttocks on the edge of the bed. This made it easier for the conduct nurse to deliver her.

Mrs K. was encouraged to rest between each contraction, so that she could relieve her pains as much as possible when they occurred.

When each contraction occurred a nurse held Mrs K's right leg up at right angles to her body and parallel to the bed, with the knee bent in a right angle. This makes it easier for Mr K. to bear down with each contraction and it is out of the way of the conduct nurse, while she is delivering the baby. When the contractions ceased her leg was placed on the bed again, so that Mrs K. could rest.

During this stage Mrs K. only took sips of water and she did not pass urine.

Mrs K. was not left alone in theatre and was given comfort and reassurance by the nurse.

In the theatre the nurses and other attendants wore aprons and masks and Mrs K's vulva was exposed as little as possible to prevent infection entering.

5) Relief of Pain:

To help relieve the pain during the second stage Mrs K. was given nitrous oxide and oxygen machine to use. The gases were inhaled

by her when she was having a contraction, and they helped to (remove) believe to pain. The preparation was 60% oxygen and the % of oxygen oxide until the baby's head was crowned then the preparation of nitrous oxide was increased to 60%.

3.) Observations:

Mrs. K. had frequent strong uterine contractions throughout the second stage and the presenting part of the baby advanced rapidly until it was born.

At the beginning of the second stage Mrs. K.'s membranes ruptured and clear liquor escaped.

The fetal heart was checked at the beginning of the second stage and was found to be satisfactory.

Although Mrs. K. became distressed at times during the second stage she co-operated very well and obeyed instructions.

No complications occurred during this stage.

4.) Preparation for Delivery:

The nurse who was to deliver Mrs. K. prepared herself by putting on a turban and then scrubbing her hands and forearms for 3 minutes. She then put on a sterile gown and proceeded to prepare Mrs. K. as follows:-

The vulva and approximately 10 inches

width inside each leg down to the knee were swabbed with Sabson 1:100 and the tubercine cream. The nurse then put on sterile gloves and put sterile drapes across the A. one across her lower leg and one across above her legs. There was then a sterile field for the delivery of the baby.

5.) Preparation for Baby:

A hot water bottle was put in the cot to warm it ready for the baby.

The suction was placed on the end of the bed with a sterile suction tube on the end and just before the baby was born it was turned on.

Labels were prepared to identify the baby.

6.) Delivery:

Mrs. K. was delivered in the left lateral position. When the baby's head was crowned, a pad was placed over the anal area and the chin was held out by the cord with nurse's hand, taking care to guard the perineum. The brow, face and chin swept over the perineum and the head was born. The nurse quickly rinsed her hands and inspected the baby's neck to see if the cord was around it but it was not observed.

The eyes were swabbed with wool swabs and the mouth was cleaned with a piece of gauze.

External rotation of the head then occurred aided by the cord-cut nurse.

Slight traction was then applied to the baby's head and the shoulders were brought to the rest of the baby's body was then born by lateral flexion, the baby being taken up over the mother's abdomen.

From the time the head was crowed until the baby was born Mr K was asked not to bear down with her contractions, but to "pant" using the gas and oxygen machine.

There were no tears in Mrs K's perineum.

Management of the Third Stage:

1) Care of the Baby:

Immediately after the baby was born his airways were cleared by suction and he began to cry well.

The cord was clamped with two forceps an inch apart and approximately 4 inches away from the baby. A cord tie was then applied next to the baby and the cord was cut. A cord clamp was then applied where the forceps were, iodine was applied to the end of the cord and a piece of linen was placed over it.

The baby was then taken to his cot where nappy pads were applied to him and he was wrapped up and placed on his right side facing the head so that he could be observed

easily.

2) Position:

As soon as the baby was removed a kidney dish was placed close to the vulva with the cord in it.

Mrs K. was then turned on her back. The cord-cut nurse then placed a flesh guard over Mrs K's knees and put a clean kidney dish in place. A sterile hand towel was placed over Mrs K's abdomen. The nurse now waited signs of descent of the placenta.

3) Signs of Descent of the Placenta.

The following are signs of descent of the placenta that could indicate separation, although any one sign is not a sure indication:

- Rising up of a well-contracted fundus - about 1 inch above the umbilicus.
- Lengthening of the cord outside the vagina.
- A small gush of blood from the vagina.
- Upper segment of uterus is freely movable and is very near to the anterior surface of the abdomen.
- Placenta seen at vulva.

Watching for these signs the cord-cut nurse knew when Mrs K's placenta was ready to be delivered.

4) Expulsion of Placenta:

Using her left hand the nurse pushed Mrs K's uterus up in her abdomen and

pressed gently on the cord. It soon appeared at the vulva and nurse caught it in her left hand as it was expelled, and gently wiped the membranes out. It was placed in the kidney dish.

The nurse felt the R's fundus but could not express any blood clots and the blood loss had almost ceased at the time. Reflexus was well coordinated.

5.) Prevention of Hemorrhage:

Immediately the placenta was delivered 0.5 mgm of Ergometrine was administered intra-muscularly to Mrs K. This aided the contraction of the uterus so clamping the blood vessels.

Good 1st and 2nd stage management are also necessary to prevent post-partum hemorrhage.

Prevention of Infection:

It was necessary for the nurse to use good sterile technique during the delivery and immediately after to prevent Mrs K developing any infection. Special points are the redraping for the 2nd stage, the clean kidney dish for the reception of the placenta and the adequate use of antiseptic for swabbing and tying of cords.

Mrs K did not develop any infection.

7.) Immediate Post-Partum Care:

When the 2nd stage was completed Mrs K was re-swabbed and a sterile drape was put in place. The upper

drawsheet on the table was removed and her rightness was changed. She was now lying on a clean table with dry clothes on.

Mrs K was then given her new son to hold for a short while and then given a cup of tea which she much appreciated.

Mrs K was then left to rest for an hour.

8.) Examination of the Placenta:

The nurse took Mrs K's placenta to the sluice room where she examined it for any abnormalities.

The membranes appeared complete and all the cotyledons present on the maternal surface. The short cord was inserted laterally and contained 3 blood vessels.

No abnormalities were present.

Record of 1st and 2nd Stage of Labour:

Commencement of Labour: 8 pm on 30.1.63.

1st Stage Length: 21 hours, 45 minutes.

2nd Stage Commenced 4.35 pm on 31.1.63. Length 5 minutes.

3rd Stage commenced 4.50 pm on 31.1.63. Length 5 minutes.

Hours in labour: 21 hours, 30 minutes.

Presentation and Position - Vertex left occipito anterior. Head - short, pulsating - 3 vessels.

Placenta - normal, complete, delivered by expression.

Perineum - intact.

Labour - normal.

Character of contractions - Strong and Expansive.
Blood loss - measured 120g. Estimated 40g.

Membranes - complete.

Liquor amnii - clear.

Baby:

Mother's name: Mrs K.

Sex: Male.

Alive.

Period of gestation: 40 weeks

Mrs K. was thrilled with her baby son and was looking forward to caring for him. She was a co-operative and pleasant patient but she was very pleased her labour was a successful one.

G. S. Saunders

11.2.63.

Anti-natal Case History.

Name: Mrs L.

Age: 28 years.

No. of Pregnancy: 2nd + 2 miscarriages. ∴ 4th.

1st day of last menstrual period: 16th April 1963

Expected date of delivery: 21st January 1963

Pre-pregnant weight: 10.5m.

Height: 5ft 6ins.

Aims of Anti-natal care

1. To promote and maintain good physical and mental health during pregnancy.
 2. To ensure a live healthy mature baby.
 3. To prepare the woman for labour, for location and the subsequent care of her baby i.e. physical, psychologically and mentally.
 4. To detect early and check appropriately any conditions medically or obstetrically which may affect the mother or baby.
 5. Education of father.
- First Visit.

Date of Booking: 12.10.62.

When Mrs L. attended anti-natal clinic for her first visit she was welcomed by sister and nurse and the above and following particulars were taken. Mrs L. brought with her a note from her doctor requesting that she be booked in for her delivery and giving her expected date of delivery and requesting blood group and haemoglobin.

Personal Particulars.

Country of Birth: New Zealand.

Nationality: European.

Husband's Occupation: Builder.

Religion: Roman Catholic.

The following particulars were also taken:-

Family health - no disease of any consequences, but multiple pregnancies - twins both sides of family.

Husband's health: good.

Patient's present health: good.

Patient's Previous Obstetrical History.

October 1961. - Caesarian section at Hamilton for foetal distress, after a normal full term pregnancy. Length of labour 30 hours. Baby's birthweight was 7.4 lbs and he was breast fed for 3 months.

Mrs. L. had also had 2 miscarriages in 1960 at home.

When all these particulars had been obtained Mrs. L. was weighed without her coat and shoes and this was recorded as 118.9 lb.

Mrs. L. was given a list of requirements to bring with her to hospital and she was also a lot of abnormal signs that she may notice and which she could report to her Doctor immediately. These included headache and dizziness, swelling of the face, hands and feet and blurred vision.

Mrs. L. was also given an ante natal card with the date of her next appointment at the clinic this was for just over a month time on the 28. 11. 62. She was asked

to bring an early morning specimen of urine with her on each succeeding visit.

Mrs. L. was advised to eat a good diet which included plenty of milk drinks and milk puddings, and she must have plenty of rest and sleep between caring for her young son.

Mrs. L. was also observed to be wearing clothes that were not too tight and sensible low heeled shoes.

Mrs. L. was also told about the relaxation classes that are held each week but she decided not to attend them.

The nurse then took Mrs. L. up to the laboratory where a sample of blood was taken (plate counted) and a haemoglobin done.

Subsequent Visits.

Before Mrs. L.'s next visit the result of her blood examination came back it was as follows:-

Group: "A"
Rhesus: Positive.
Haemoglobin: 86%

28. 11. 62.

Mrs. L. was welcomed and then taken through and weighed. Her weight was 128.1 lb. She was then taken to a cubicle where she was asked to take off her outer garments

and put on a gown so that she could be examined.

The urine was tested while she was getting changed and no abnormalities were detected.

Mrs. L. was taken to the examination room and she was helped on to the couch, with her shoulders on the couch and her knees slightly bent, in the dorsal position.

The nurse now took Mrs. L.'s blood pressure and this was $100/80$. It was recorded on her Ante-Natal Card. Mrs. L. was asked when she last felt foetal movements and she had that day.

The nurse now made an abdominal examination of Mrs. L. and felt for the following:-

Approximate height of fundus: $\frac{80-85}{40}$ weeks

Presentation of foetus: Right occipito lateral.

Position of foetal head: Above pelvic brim.

Foetal heart: Heard.

Mrs. L. said she had felt well and the nurse now made a general examination to detect any abnormalities such as swelling in the face, hands and feet, varicose veins and any skin infections.

Mrs. L. was given advice re healing her breast - by rubbing lanolin in and good hygiene.

A raised blood pressure or presence of albumen in the urine or oedema would show

signs of toxæmia. Except for slight varicose veins Mrs. L. was very healthy.

Any questions Mrs. L. asked were answered by the nurse and she was assisted off the couch and went to get dressed. Mrs. L. was given an appointment card for her next visit.

19.12.62.

Mrs. L. arrived in good time for her appointment and was examined in the same manner as before.

Her weight was now 12st. 3.5lb. Mrs. L. weight gain was satisfactory.

Her blood pressure this time was $140/90$ and no abnormalities detected in her urine.

Mrs. L. was still keeping in good health. This was Mrs. L.'s last visit to Ante-natal Clinic before delivery but she continued to visit her Doctor as often as he thought necessary.

The information she had gained would be of some guide for the midwife as to what could occur during the delivery. It was hoped that some benefit had been obtained by Mrs. L. from her visits to Ante-natal Clinic and that she approached the delivery of her baby in the best possible mental and physical health.

The time spent by each nurse in Ante-natal Clinic is of value in teaching them how to observe and teach pregnant women how to take the best possible care of themselves.

Incomplete. C. S. Saunders
11.2.63.

The Danger signals:-

1. Vaginal discharge which the patient must report to her doctor, likewise the following complaints.
2. Vomiting.
3. Nausea.
4. Constipation.
5. Urinary troubles.
6. Cessation of foetal movements.
7. Severe headaches and dizziness.
8. Swelling of the hands and feet, and possibly the face.
9. Fits or convulsions.
10. Faintness, or shortness of breath.
11. Abdominal pain.

When the patient attends her doctor or ante-natal clinic she is given advice regarding the onset of labour.

The commencement of uterine contractions and the presence of a show (blood and mucus.)

Rupture of the membranes or breaking of the waters. The patient should be asked if she has noticed a gush or trickling of water.

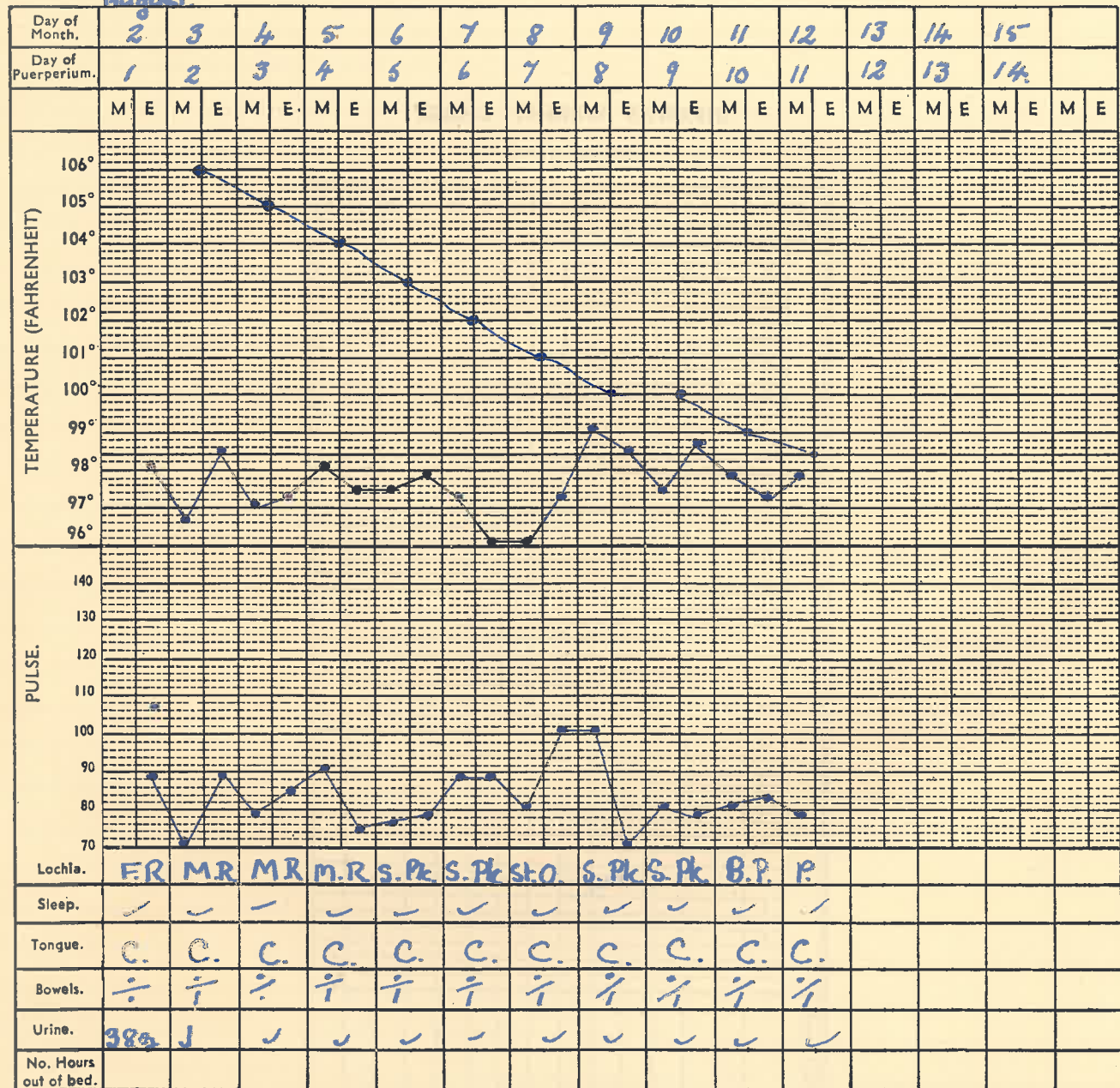
Enquiry should be made as to whether the patient has had any sleep or has been kept awake with false, nagging pains.

The Principles in the nursing care of the Puerperal Woman:-

1. To prevent the entrance of bacteria into the vagina and these raw surfaces be infected.
2. To keep the vulva and perineum as dry as possible, since dryness is inimical to germ growth.
3. To promote drainage from the uterus and vagina, thereby removing the lochia discharges as quickly as possible.

Mrs. G.E.B.

August



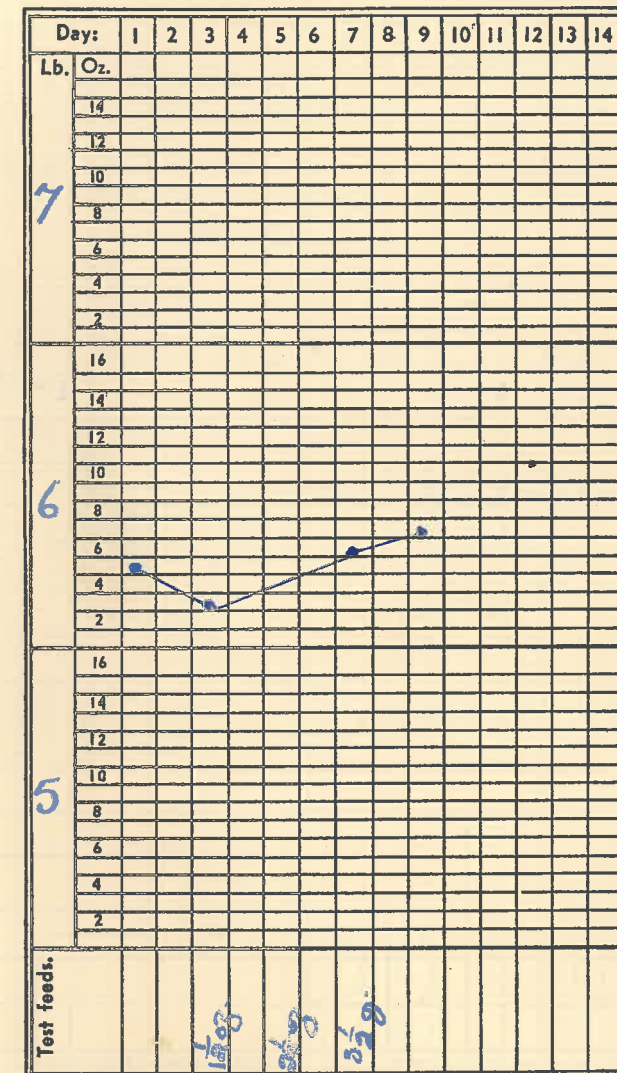
ABBREVIATIONS.—LOCHIA. F.=Free; M=Moderate; S=Scanty; R=Red; Pk.=Pink; Br.=Brown; P.=Pale; O.=Offensive.
TONGUE: C.=Clean; Cd.=Coated. BOWELS. Ap.=Aperient; En.=Enema; L.=Loose. PREFIX: V.=Very; St.=Slightly.

2w.
28.8.60

Baby. G.E.B.

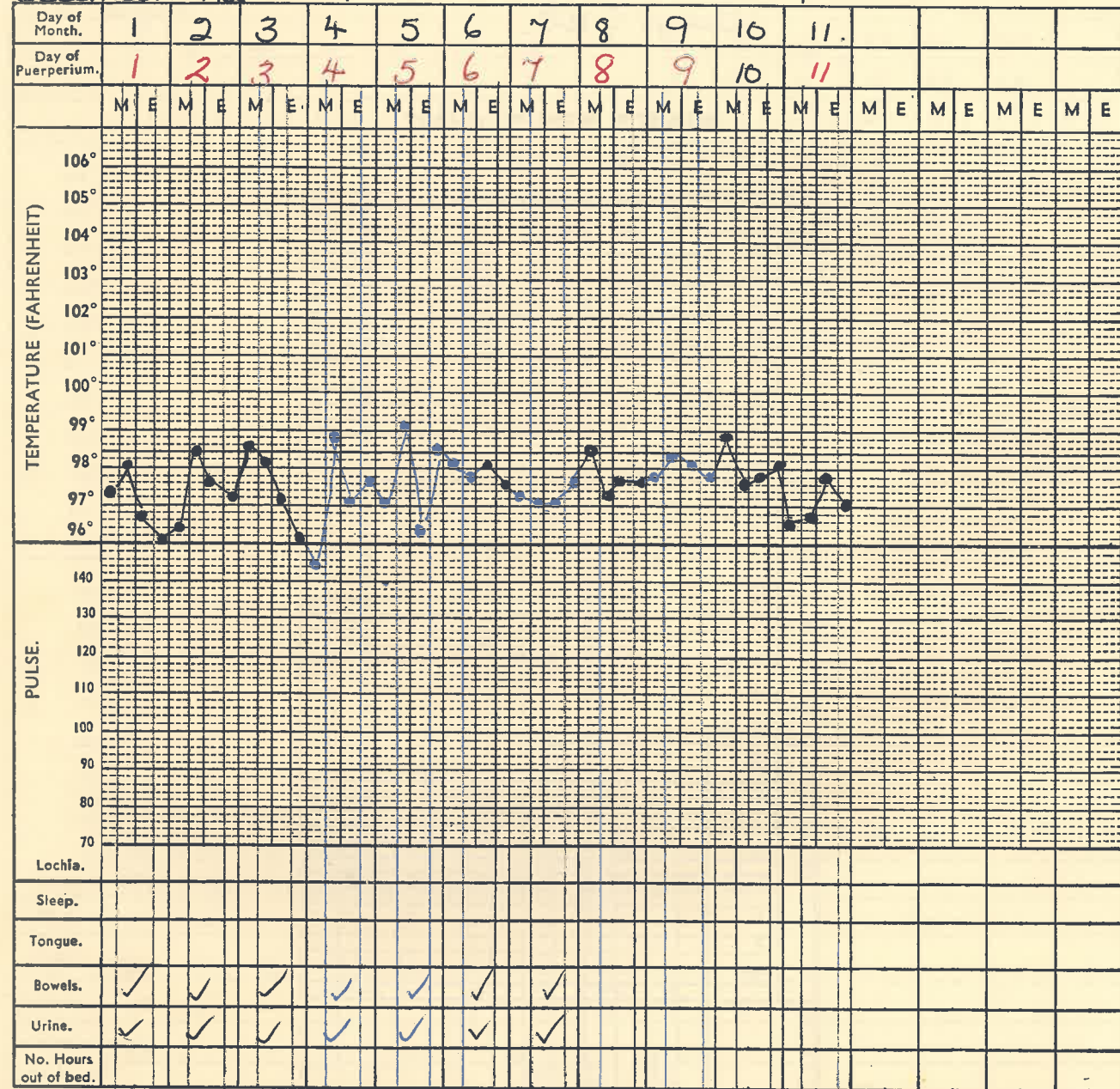
INFANT'S WEIGHT CHART

(Movable Scale)



2w. 28.8.60

Premature Baby. Baby M's Temperature Chart.



ABBREVIATIONS.—LOCHIA., F.=Free; M=Moderate; S.=Scanty; R.=Red; Pk.=Pink; Br.=Brown; P.=Pale; O.=Offensive.

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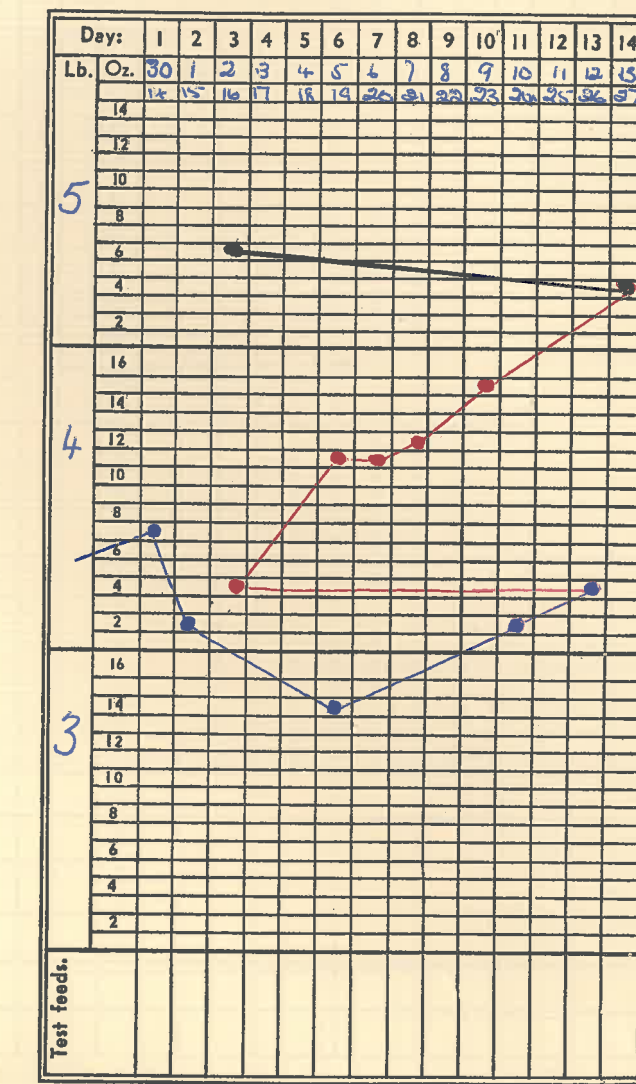
E. J. Saunders

11.2.63

[H.—Mt. 15

Baby M's. Weight Chart.

Premature INFANT'S WEIGHT CHART
(Movable Scale)



E. J. Saunders

11.2.63.

