VOLTA REGIONAL HOSPITAL

IPD ADMISSION SUMMARY

Report Generation Date Time: 09-11-2025 06:15:10

Patient Information

Surname:	JARIYA	**Other Names:**	TAMIMU
Patient No.:	VR-A01-AAA2142	**Gender:**	Female
DOB:	03-02-1992	**Age:**	33 Year(s)
Admission Date:	30-08-2025	**Admission Time:**	15:17
Admission No.:	ADMT-22362		

Ward/Room History

#	Ward/Room	Bed No.	From Date	From Time	To Date	To Time	Transfer Reason	Status
1	Ward Labour Ward	Bed1	30-08-2025	15:17	31-08-2025	11:27	-	Discharge

Treatment Details

#	Date	Time	Doctor	Notes
1	31-08-2025	11:26	Dr. Princewill Soni-Obele	Now P3 Delivered via SVD yesterday Seen with no complaints. O/E : GC stable. P+, J-, F-. Asymptomatic of anemia. Uterus well contracted. HB 9.6g/dl Plan - Discharged - PNC 1/52
2	30-08-2025	18:38	Humu Adamu	-
3	30-08-2025	18:36	Humu Adamu	-
4	30-08-2025	17:42	Daniel Awoyade	-
5	30-08-2025	16:29	Miriam Oketsey-Mantey	-

Recommendations

#	Procedure Name	Recommended Date	Notes
No recommendation available			

Prescriptions

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#	Drug Name	Frequency	Dose	Days	Quantity
1	**Amoxicillin + Clavulanic Acid Tablet** [Amoxicillin + Clavulanic Acid Tablet | 500 mg + 125 mg | Tablet - From **30-08-2025** To **05-09-2025**]	BDS	625MG MG	7	17
2	**Chloramphenicol Eye Drops** [Chloramphenicol Eye Drops | 0.005 | Drops - From **30-08-2025** To **30-08-2025**]	BDS	1 Drops	1	0
3	**Chlorhexidine Gel** [Chlorhexidine Gel | 7.1 % (digluconate) delivering 4% chlorhexidine | Gel - From **30-08-2025** To **05-09-2025**]	BDS	1 Cream	7	0
4	**Paracetamol Tablet** [Paracetamol Tablet | 500 mg | Tablet - From **30-08-2025** To **03-09-2025**]	BDS	1000 MG	5	20
5	**Phytomenadione Injection** [Phytomenadione Injection | 1 mg/mL (Paediatric) | Injection - From **30-08-2025** To **30-08-2025**]	Stat	1 MG	1	0
6	**Sodium Chloride Infusion (0.9% (500 mL))** [Sodium Chloride Infusion | 0.9% (500 mL) | Infusion - From **30-08-2025** To **30-08-2025**]	BDS	2000 mL	1	0
7	**Infusion Giving set** [Infusion Giving set | | KIT - From **30-08-2025** To **30-08-2025**]	Stat	1 mL	1	0
8	**Oxytocin** [Beltocin | 10IU/ml | Injection - From **30-08-2025** To **30-08-2025**]	Stat	10 IU	1	0
9	**Paracetamol Infusion** [Paracetamol infusion | 1G | Infusion - From **30-08-2025** To **30-08-2025**]	TDS	1 g	1	0
10	**Tranexamic Acid** [Tranexamic Acid | 500mg/ml | Injection - From **30-08-2025** To **30-08-2025**]	Stat	2 MG	1	0

Vitals

Vital Name	**06:00 AM**(31-08-2025)
SpO2	99 % - Room Air-RA
Respiration Rate	19 Per Min
Blood Pressure	131 mmHg - 68 mmHg
Pulse	67 Per Min
Temperature	36.1 Celsius - Axilla

Doctor & Nurse Notes

#	Notes	Type	Added By	User Type	Added On
1	Client and baby taken up in a stable condition ,mother encourage to breastfeed.	Doctor Notes	OSALII AKAFIA	Doctor	31-08-2025 11:26

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#	Notes	Type	Added By	User Type	Added On
2	REST AND SLEEP: Client and her baby slept well nocte and lodged no complaints this mane. NURSING INTERVENTION: She was reassured of care and encouraged to continue to breastfeed baby. Moderate lochia rubra seen on perineal pad inspection, uterus is well contracted. Vital signs were checked and recorded as T-36.1degrees celcius pulse-67bpm, R-19cpm and BP-131/68 mmHg. Personal hygiene was maintained for both mother and baby. Her due medication administered.All other needed nursing care rendered. NUTRITION: Client took koko with bread for breakfast. ELIMINATION: Client has not yet moved bowel this mane and she is voiding normally EVALUATION: Condition ofmother and baby this morning is satisfactory. Monitoring is in progress	Doctor Notes	Felicia Kpodo	Doctor	31-08-2025 06:32
3	Addendum, client alleged that she ruptured membranes at12pm in the house before coming to the hospital	Doctor Notes	Deborah Yomele Wayoe	Doctor	30-08-2025 21:56

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#	Notes	Type	Added By	User Type	Added On
4	ADMISSION:Client walked into the ward at 1:50am accompanied by her relatives. HISTORY: Client G4P2A+1 with 39 weeks + 3days gestation, EDD 03/09/25 by scan, an attendant of Adabraka Health Centre with a total of 10ANC visits presented with lower abdominal pains and waist pains onset 10am today. MED/SURG HISTORY:Client has no medical nor surgical history SOCIAL HISTORY:Client does not smoke nor drinks alcohol. OBSERVATION AND ASSESSMENT:On arrival was a pregnant woman fully conscious and in obvious pain but could give good account of herself. She is not looking pale nor jaundiced. No abnormality seen on head to toe examination. NURSING DIAGNOSIS:Acute Pain Related To painful uterine contractions. OBJECTIVES/OUTCOME:Client will be able to cope with pain throughout the process of labor. ORDERS: -Reassure client and relatives of competent care. -Monitor vital signs and record -Secure IV line, take sample for FBC, -Check urine glucose and protein -Do abdominal and vaginal examination -Monitor client for possible SVD -Inform ward doctor for review -Explain all procedures to client and document findings NURSING INTERVENTION: Client was received into a comfortable bed and was reassured of competent care. Baseline vital signs checked and recorded as T-36.5, P-83bpm, R-20cpm and B/P-124/69mmHg. Urine protein-Negative Urine glucose-Negative. On abdominal examination, SFH - 35cm FHR -136-144bpm. Presentation - breech Lie: Longitudinal Timed contractions on palpation 4:10 lasting 55-60 secs. On vaginal examination, cervix was fully effaced, 10cm dilated, membranes ruptured before arrival liquour clear,client was assisted into the delivery room with feet in vagina.Client was positioned and encouraged to bear down with contractions and rest in between. Ward doctor was around hence he was informed and immediately came to assist in delivery. At 1:58pm Client had a successful delivery to a live female neonate who was delivered onto mother's abdomen. Baby was thoroughly cleaned and Cord clamped and cut at 1:59pm, baby separated from mother for suctioning and stimulation. AS-6/10 and 8/10 for first and fifth minutes respectively. Baby shown to mother for identification of sex and then congratulated. Skin to skin continued. Third stage actively managed and completed at 2:55pm without any complications. EBL-150ml. Perineum was intact on inspection. Essential care findings for baby were as follows wt-2.6kg, HC-35cm FL-47cm, HR-142bpm Resp-41cpm, RBS-3.4mmol/l.Baby put to breast as mother encouraged to breastfeed. NUTRITION: Client took Tuo and dry okro soup. ELIMINATION: Voids normally and has moved bowel once before arrival Discharge Plan: Client will be educated on the following after a successful delivery, exclusive breastfeeding, nutrition , family planning and liaise with the public Health unit for continuity of care. EVALUATION: General condition on arrival was stable.	Doctor Notes	Humu Adamu	Doctor	30-08-2025 19:20

Admission Chief Complaint

#	Chief Complaint
1	LAP, WAIST PAIN

Additional Services

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#	Additional Procedure	Rate Type	From Date	From Time	To Date	To Time	Notes
1	Feeding	Daily	30-08-2025	07:46 PM	NA	NA	NA

Diagnosis

#	Type	Code	Description	Code Status	Date
1	ICD10 Code	O80.9	Single spontaneous delivery, unspecified	New	31-08-2025

Operations

#	Surgery	Date	OT	Timing	Chief Surgeon	Anesthetist
1	Spontaneous Vaginal Delivery with or without Episiotomy	31-08-2025	General Operation Theater	00:01 - 00:01	-	-

Diet

#	Menu Type	Menu Name	From Date	To Date
No diet available				

Clinical Notes

Sr.No.	Note
No Notes Available	