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PREFACE

The practice of midwifery in the past focused mainly on the client in an effort to meet the client's needs. However, all the needs of client could not be met because they lacked family support.

Again, Midwifery has undergone a lot of changes globally and nationally. These changes have brought the introduction of client and family centered maternity care concept. The concept of family centered maternity care is a systematic way by which a comprehensive maternity and nursing care is given to a pregnant woman and her family throughout pregnancy, labour and puerperium by the use of the nursing care process. The confidentiality of the client is ensured and client feels at ease to provide vivid history and discussions on confidential matters.

This system gives the student midwife the opportunity to use all the knowledge and skills acquired during her training to give quality maternity care to the pregnant women and her family throughout the period of pregnancy, labour and puerperium.

The study also enables the student midwife to identify and help clients solve their health problems. To achieve this, the student identifies the health problems, assess the client, set objectives, provide the necessary interventions, and evaluate the care to know if goals have been fully met at the end of the care.

The care study forms part of the academic exercise from the Nursing and Midwifery Council of Ghana which serves as a partial fulfillment towards the award of a registered midwifery certificate.

ACKNOWLEDGEMENT

My sincere gratitude goes to God almighty for granting me the knowledge, wisdom, understanding and strength to reach this far.

My next thanks is to the Principal of the Nursing and Midwifery Training College, Berekum Ms. Monica Nkrumah, my supervisor, Ms. Ernestina Mensah, teaching and non-teaching staff of this noble institution for their support and knowledge imparted in me.

My client Madam Yakubu Alima and her family especially her husband who cannot be left out because they allowed themselves to be used for the study. My profound gratitude goes to the Midwife In-Charge of Dormaa West District Hospital, Ms. Joyce Naazie and her entire staff for their time, guidance and advice throughout this period.

A special thanks to my father Mr. William Yeboah Gyan and mother Ms. Faustina Konadu, my siblings, friends and the entire family for the sponsorship, encouragement and support they rendered to me. Not forgetting everyone who helped me either physically or spiritually especially Rev. Adu Yeboah and Mr. Prempeh Collins. I say God bless you all.

Authors of the various books used for the study cannot be left out because their books helped me to acquire the needed information and understanding for the study. I say, thank you very much.

INTRODUCTION

The family and client centered maternity care study entails the client's particulars, care rendered to the client and her entire family and the community during pregnancy, labour and puerperium.

During home and health center visitation, information, observation, examination and every details about the client that was necessary for the study was obtained, which aimed at healthy labour outcome leading to no complications to both mother and baby.

This particular care study is about Madam Alima, a 31 years old woman gravida 3 para 2 during her period of pregnancy, labour and puerperium. The care started from the 2nd of December, 2020 at Dormaa West District Hospital of Bono Region, Ghana, after familiarity was built between myself and Madam Alima at the antenatal hospital. It was not surprising when she kept complaining of loss of appetite. Opportunity was taken to educate her on the physiology behind that and was educated to eat in bit and at frequent intervals and also to perform proper mouth care. It was her ninth antenatal visit and her gestational age was 36 weeks. After a comprehensive introduction, she was informed about the idea of using her for the care study which she happily agreed. Permission was granted by the midwife in-charge for client to be chosen for the care study.

Madam Alima was cared for during the antenatal periods. Visitation to her home was made to know her family, her surroundings and the community in which she lives. Client and her entire family were included in the care. The condition from the beginning till the end of the interaction

was satisfactory. Madam Alima had a successful pregnancy, delivered spontaneously on 29th December, 2020 to an alive baby boy. She had a successful puerperium and was in good health. She was then handed over to the midwife in-charge at Dormaa West District Hospital for continuity of care on the 7th of January, 2021 who in turn handed her over to the Public Health nurses again for continuity of care. This care study is in four chapters;

Chapter one talks about client's particulars followed by chapter two which is also the antenatal care rendered to Madam Alima throughout her pregnancy and chapter three is concerned about management during labour. Lastly, chapter four gives an account of the management of puerperium with emphasis on care of the mother and baby, from day of delivery to seven days after delivery and seventh post natal visits. The script also include summary, conclusion, bibliography, appendix like laboratory investigations, antenatal records, pharmacology of drugs and signatories.

LITERATURE REVIEW

PREGNANCY

Tiran (2008) defined pregnancy as from conception to delivery of the fetus; normal duration is two hundred and eighty days (280 days, 40 weeks or 9 months and 7 days), counted from the first day of the last normal menstrual period to delivery, or two hundred and sixty five days (265), from conception to delivery.

King (2014) stated that, the prenatal period covers the time from the first day of the last normal menstrual period to the start of true labour, which marks the beginning of the intrapartum period.

Henderson (2009) stated that, Pregnancy may be suspected by the woman based on her knowledge of her menstrual cycle, sexual activity and the signs and symptoms of pregnancy. Women may confirm their pregnancy using a home pregnancy test.

Henderson (2009) further stated that, confirmation of pregnancy may also be sought from midwife or doctor. This is established by a detailed history and relevant clinical examination based on the signs and symptoms of pregnancy. The signs and symptoms of pregnancy are; amenorrhoea, breast changes, nausea and vomiting, increased frequency of micturition, enlargement of the uterus, skin changes and quickening. These signs will become obvious to the woman in sequential stages. The signs and symptoms of pregnancy may be considered as presumptive, probable and positive (Henderson, 2009).

King (2014) also stated that, the prenatal period is divided into trimesters, the first trimester is considered to be 1 to 12 weeks because organogenesis is completed at the end of twelve weeks (12) and the risk for spontaneous abortion is significantly reduced at this time. Historically, the second trimester was considered to be weeks 13 to 28 because prior to the introduction of modern neonatal intensive care techniques 28 weeks was the limit of viability. The third trimester extends from 28 to 40 weeks. The term 'post-date' or 'post term' is typically used to describe a pregnancy beyond forty (40) weeks.

According to King (2014), pregnancy is a time of profound anatomic and physiologic changes in a woman's body. In addition to the reproductive organs all maternal physiologic systems 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.

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 adaptations to the increasing demands of the growing fetus. Unless well understood, this physiological adaptation of normal pregnancy can be misinterpreted as pathological.

Konar (2013) further stated that, there is enormous growth of the uterus 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 900-1000g and measures 35cm in length. The capacity is increased by 500-1000 times and changes occur in all the parts of the uterus. There is increase in growth and enlargement of the body of the uterus. Not only the individual muscle fibres increase

in length and breadth but there is limited addition of new muscle fibres. These occur under the influence of the hormones; oestrogen and progesterone limited to the first half of pregnancy but pronounced up to twelve weeks (12). Three (3) distinct layers of muscle fibres are evident; outer longitudinal, inner- circular and intermediate. Normal anteverted position is exaggerated up to eight (8) weeks. Thus the enlarged uterus may lie on the bladder rendering it incapable of filling, clinically evident by frequency of micturition. Afterwards, it becomes erect; the long axis of the uterus conforms more or less to the axis of the inlet.

Fraser and 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 muscle and elastic tissues of the wall. In late pregnancy, the bladder mucosa becomes oedematous due to venous and lymphatic obstruction especially in primigravida following early engagement. Increased frequency of micturition is noticed at 6-8 weeks of pregnancy which subsides after 12 weeks. It may be due to resetting of osmoregulation causing increased water intake and polyuria. In late pregnancy, frequency of micturition once more reappears due to pressure on the bladder as the presenting part descends down the pelvis. Stress incontinence may be observed in late pregnancy due to urethral sphincter weakness.

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 acid gastric content into oesophagus may produce chemical esophagitis and heart burn. There is diminished gastric

secretion and delay emptying time of stomach. Risk of peptic ulcer disease is reduced. Atonicity of the gut leads to constipation while diminished peristalsis facilitates more absorption of food materials.

According to Ghana Health Service (2008), Antenatal Care (ANC) is the health care and education given during pregnancy. Antenatal services are an important part of preventive and promotive health care. The objectives of ANC include:

1. To promote and maintain the physical, mental and social health of the mother and baby by providing education to the pregnant mother on nutrition, rest, sleep, personal hygiene, family planning, immunization, danger signals STI/HIV/AIDS birth preparedness and complication readiness.
2. To detect and treat high-risk conditions arising during pregnancy, whether medical, surgical or obstetric.
3. To ensure the delivery of a full term healthy baby with minimal stress or injury to mother and baby.
4. To help prepare the mother to breastfeed successfully, experience normal puerperium and take good care of the child physically, psychologically and socially.
5. To ensure safe delivery and postpartum health.
6. To ensure quality care, antenatal care services must be organised in such a manner that it will provide comprehensive and individualised care. As much as possible, all care activities for example history taking, physical examination and treatment should be provided by the same care provider to the pregnant woman. (Focus Antenatal Care).

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.

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

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 descent 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.

Fraser and Cooper (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 baby and can influence the likelihood and/ or experience of future pregnancies.

Fraser and Cooper (2014**)** further stated that, human pregnancy is considered to last approximately 40 weeks, with labour usually occurring between 17 and 42 weeks gestation. Complex physiological and psychological changes occur during the last few weeks of pregnancy and also during the onset of labour that prepare the woman for the process of labour and birth.

Fraser and Cooper (2014) stated that, traditionally, three stages of a 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:

1. First stage starts from the onset of true labour pains and ends with full dilatation of the cervix. It is in other words, the 'cervical stage' of labour. Its average duration is twelve hours (12) in primigravidae and six hours (6) in multiparae.
2. Second stage starts from the full dilatation of the cervix (not from the rupture of the membranes) and ends with expulsion of the fetus from the birth canal. It has got two (2) phases thus the propulsive phase starts from full dilatation up to the descent of the presenting part to the pelvic floor and the expulsion phase is distinguished by maternal bearing down efforts and ends with delivery of the baby. Its average duration is two hours (2) in primigravidae and thirty minutes (30) in multiparae.
3. Third stage begins after expulsion of the fetus and ends with expulsion of the placenta and membranes (after-births). Its average duration is about fifteen minute (15) in both

primigravidae and multiparae. The duration is, however, reduced to five minutes (5) in active management.

1. Fourth stage is the stage of observation for at least one hour (1) after expulsion of the after-births. During this period, general condition of the patient and the behaviour of the uterus are to be carefully monitored.

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

Fraser and Cooper (2009) stated the following about the First Stage

1. The latent phase is prior to active first stage of labour and may last 6-8 hrs. in first time mothers when the cervix dilates from 0 cm to 3-4 cm dilated and the cervical canal shortens from 3cm long to <0.5cm long.
2. The active first stage is the time when the cervix undergoes more rapid dilatation. This begins when the cervix is 3-4cm dilated and, in the presence of rhythmic contractions, is complete when the cervix is fully dilated (10 cm).
3. The transitional phase is the stage of labour when the cervix is from around 8 cm dilated until it is fully dilated (or until the expulsive contractions during second stage are felt by the woman). There is often a brief lull in the intensity of uterine activity at this time.

According to Fraser and Cooper (2014), the onset of labour is process, not an event; therefore it is very difficult to identify exactly when the painless (sometimes painful) contractions of pre-labour develop into the progressive rhythmic contractions of established labour. Diagnosing the onset of labour is extremely important, since it is on the basis of this finding that decisions are made that will affect the intrapartum care and support subsequently provided.

King (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 membranes, bloody show or increased mucus discharge from the vagina, maternal perception of increased energy, gastrointestinal distress. (Henderson, 2009)

King (2014) also 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).

According to Henderson (2009), the aims of midwifery care in labour are to achieve a safe labour and birth for mother and baby, and a pleasurable, fulfilling experience of child birth for the mother and her partner.

In order to give woman-centered care, the midwife should:

1. Assess the needs and expectations of each individual woman regarding labour and birth.
2. Plan care with each woman in labour that is tailored to meet her specific needs and expectations.
3. Put the care plan into practice, and

4. 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 a woman'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 woman and her partner and the midwife, particularly in relation to examinations and their findings. Being fully informed and involve in decision-making helps the woman 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; patient is encouraged to pass urine by herself as full bladder often inhibits uterine contraction and may lead to infection. If the woman cannot go to the toilet, she is given a bed pan. Privacy must be maintained and comfort must be ensured. If the patent fails to pass urine especially in late first stage, catheterisation is to be done with strict aseptic precautions.

Fraser and Cooper (2014) also stated the following under bath or shower: Immersion in a warm bath or birthing pool can be an effective form of pain relief for labouring women that facilitates increased mobility with no increased incidence of adverse outcome for the woman or fetus. This 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 patient 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 of 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. Partographs are the graphical representation of the salient features in the first stage of progress of labour which provides the opportunity for early identification of deviation from normal. They aid in the early detection of abnormal labour progress and are credited by some for decreasing rates of prolonged labour, oxytocin use, caesarean sections and intrapartum morbidity/mortality as compared to usual care. Use of the partograph is initiated during presumed active labour.

Henderson (2009) stated the following under vaginal examination; this procedure is one of the options to help confirm the onset of labour. However, it is invasive and often very uncomfortable for the women and also poses a potential infection risk. Women may request it in seeking reassurance about the status of labour.

According to Konar (2013), the transition from the first stage to the second stage is evidenced by the following features:

1. Increasing intensity of uterine contractions.
2. Urge to defecate with descent of the presenting part.
3. Complete dilatation of the cervix as evidenced on vaginal examination.

According to Marshall and 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 of the birth and delivery of the placenta by the use of controlled cord traction.

PUERPERIUM

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 pregravid 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 body tissues, especially the pelvic organs revert back approximately to the pre-pregnant state both anatomically and physiologically.

Henderson (2009) further stated that, the following are some of the aims of postnatal care, the successful achievement of which will result from the contribution to care made by the midwife and other members of the multidisciplinary healthcare team.

1. To help the woman adapt to and successfully fulfil the role and responsibilities of motherhood.
2. To promote and monitor the woman and the infant's physical well-being.
3. To promote and monitor the woman's psychological well-being.
4. To assist the woman with the successful establishment of her infant feeding.
5. To foster the development of maternal-infant chosen method of attachment.
6. To foster good family relationships.

7. To educate the woman and her family in the needs and development of the infant.

8. To enhance the woman's confidence in her ability to fulfil her role as a mother to promote health education.

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

1. Involution of the uterus and other soft parts of the genital tract.
2. Commencement of lactation.
3. 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 puerpera.

Konar (2013) further 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) also stated, 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.

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:

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

Konar (2013) also added that, the average amount of discharge for the first 5-6 days is estimated to be 250ml. 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 pregravid state.

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

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

Fraser and Cooper (2009) 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 pains is by an appropriate analgesic.

WHY I CHOSE MY CLIENT

On the 2nd December, 2020, Madam Alima was chosen as client for the care study because of the opportunity gained to interact with her at antenatal clinic, when she complained of loss of appetite which was not so with her previous pregnancies. Opportunity was taken to educate her that, every pregnancy was different and was encouraged to eat in bit but at frequent intervals and to perform oral hygiene at least twice daily. It was her ninth antenatal visit and her gestational age was also 36 weeks. She was informed about the idea of using her as a client for the care study which she agreed.

She was told when the care for her and family would be over. Consent was sought for home visits, she agreed and gave direction to her house as well as her sister in-law's phone contact in order to reach her since she did not have phone for herself. Appreciation was expressed and she left happily.

CHAPTER ONE

CLIENT'S PARTICULARS

1.0 INTRODUCTION

This chapter talks about information gathered by the student midwife through comprehensive history taking, which consist of personal, social, menstrual, medical, surgical, past and present obstetric history, family history, lifestyle and hobbies of client.

1.1 PERSONAL HISTORY

Madam Alima, gravida 3 para 2 is a 31 years old lady who stays at Nkrankwanta a sub district of Dormaa West in the Bono region and a Muslim by religion. She is dark in complexion, weight's 65kg and 160cm tall. Madam Alima completed Methodist Junior High School and now a seamstress at Nkrankwanta market. She is married to Mr. Fuseni who is also a Muslim and a mechanic at Nkrankwanta. Madam Alima mentioned that, her next of kin is her first born Majid, who is eight years of age and in class five at Glorious Shepherd School at Nkrankwanta. She speaks Twi and Hausa. According to Madam Alima, she neither smokes nor drink alcohol as well as her husband. She always gets her support from her husband throughout her pregnancy.

1.2 FAMILY HISTORY

Madam Alima is the third child of Mr. and Mrs. Ibrahim. According to her, she has six siblings; four female and two male. She stated that, there are no known history of heart and liver diseases, sickle cell disease, diabetes mellitus, asthma, epilepsy, mental illness and congenital abnormalities in the family but there is a history of twin pregnancy in her family.

1.3 MEDICAL HISTORY

According to Madam Alima said she is not having any chronic illness, like hypertension, heart and liver diseases, sickle cell disease, diabetes mellitus, measles, respiratory disorder, epilepsy, and anaemia. She only said she sometimes suffers minor headache, cough and pyrexia which she visits the clinic immediately to seek for medical treatment after which she gets well. She has no known allergy to food or any drug. She went on to say that she has not received any blood transfusion or donated blood before.

1.4 SURGICAL HISTORY

She said she has never undergone any surgical procedure. She also mentioned that she has never sustained any injury that called for any abdominal or spine surgery or affected her pelvis or subsequent effect on pregnancy and labour. On examination, there was no scar indicating previous surgery or episiotomy.

1.5 MENSTRUAL HISTORY.

Client remembers her menarche in 2005 but does not remember the exact date. Her last normal menstrual period was 25th March, 2020. Client's expected date of delivery was estimated to be on the 1st January, 2021 but with the help of scan it was estimated to be 30th December, 2020. Her menses lasts for 7 days and a regular 28 days cycle. She soaks two pads a day and experiences no dysmenorrhea during menstruation.

1.6 CLIENT'S LIFESTYLE AND HOBBIES

Madam Alima is a person who sleeps at 9:30pm and wakes up at 5:00 am. Since she is a muslim, prays five times daily and she is always the first person to pray in the house that is why she wakes up early. She then brushes her teeth, sweeps her compound, empties her bin, fetches water

into her barrel and takes her bath. She cooks breakfast every day because her kids are at home due to the COVID-19 pandemic causing closure of schools and for herself. She also added that she goes to the market on Friday's at Nkrankwanta since that is their market day. She mentioned that, she likes singing very well, and prefers banku and okro stew with fried red fish to other foods. She does her laundry on weekends and continue with general cleaning. On Fridays she goes to the mosque to pray.

She uses her leisure time to sleep and watch movies .She said she eats three times daily, but ever since she became pregnant she eats on demand. She also said that she prepares lunch at 1pm and supper at 4pm. She said they sit together and take their supper around 5:00pm and she will bath and do her personal work and watch some movies, pray and go to bed. She also mentioned that she empties her bowel every morning and evening and micturate whenever she has the urge to do so.

1.7 PAST OBSTETRIC HISTORY

PREGNANCY

Madam Alima gravid 3 para 2 went through all her previous pregnancies successfully without any complication. Her first pregnancy was in the year 2011 and the second in 2015. She said during her pregnancy, she only experienced some minor disorders such as headache, backache, waist pain, lower abdominal pain, leg cramps, frequency of micturation, nausea and vomiting of which she reported to the clinic and they were explained to her as normal physiological changes in pregnancy which would resolve as pregnancy progresses. She also said she has never had any spontaneous or induce abortions and still births in her life, her pregnancies got to term. She has never suffered any pregnancy induce condition like pregnancy induce hypertension. She also

visited antenatal for at least six (6) times during her pregnancies. She has taken 3 doses of Tetanol Toxoid with the previous pregnancies and received full course of Sulphadoxine Pyrimethamine (SP) in each of the pregnancies.

LABOUR AND DELIVERY

According to Madam Alima both her first and second pregnancies went to term and labour started spontaneously in all cases, labour progressed well and Madam Alima delivered her first born at Anglogold Ashanti Hospital at Obuasi and the second at Dormaa West District Hospital – Nkrankwanta per vaginum. She further stated that the duration for her labour and deliveries did not exceed 12hours. She also said, she had a 1st degree perinea tear during her first delivery but the second was without tears. The placenta and membranes were delivered completely with no retained product of conception in both deliveries. She said her estimated blood loss was minimal. All the children cried immediately at birth. Her children never had any birth injury, asphyxia or any congenital abnormality. First child weighed 3.2kg and second 3.4kg.

PUERPERIUM

According to client, she started breastfeeding her children within the first hour after birth. She practiced exclusive breastfeeding for 6 months and then added complementary feeds after the 6 months and stopped when he was exactly 2 years. She had a safer breastfeeding with no complication. The children were fully immunized against the childhood preventable diseases. Her children never suffered any ill-health as they grow. She also did not experience any ill-health such as puerperal psychosis, anaemia, malaria, postpartum haemorrhage, puerperal pyrexia, puerperal sepsis, mastitis among others likewise her babies. In relation to family planning, she used the natural family planning method thus the lactational amenorrhoea method and after six

months, she uses condom which is an artificial method for protecting her from any unwanted pregnancy and also she began to give complementary food and also continue breastfeeding up to 2 years. She received support from her family members during her previous pregnancy especially her husband.

1.8 PRESENT OBSTETRIC HISTORY

Madam Alima G3P2 visited the antenatal clinic for the first time on 3rd June, 2020 with the gestational age of 10weeks. Client gave her last menstrual period to be 25th March, 2020. Her expected date of delivery was estimated to be 1st January, 2021 when calculated. According to client's antenatal record, she had complains of headache, bitterness in mouth and general body weakness for which she was managed. Vital signs were checked, physical examination was done and laboratory investigations were also done and the results recorded as follows;

Temperature	36.5˚c
Pulse	84bpm
Respiration	20cpm
Blood pressure	110/70mmHg
Weight	65kg
Height	160cm
Symphysiofundal height	Not palpable
Haemoglobin level	12.5g/dl
Sickling	Negative

Blood group	O+
Rhesus factor	Positive
Urine for pregnancy test	Positive
HIV	Negative
Hepatitis B	Negative
Syphilis (VDRL)	Non-reactive
Protein in urine	Negative
Glucose in urine	Negative
G6PD	No Defect
Stool for routine examination	no abnormality.

According to the result of ultrasound scan taken by Madam Alima, the expected date of delivery was 30th December, 2020 and findings were normal. Education on nutrition was given. She was given the 4th shot of Tetanus Diptheria injection as well as Long-lasting Insecticidal Net (LLIN) and was put on the following drugs;

1. Tab folic acid 5mg daily x 30

2. Tab multivitamin 200mg daily x 30

3. Tab ferrous sulfate 200mg daily x30

Client visited the Antenatal clinic subsequently for eighth times till we met on her ninth visit.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter basically deals with the first encounter with client during the antenatal period, client's subsequent visits to the antenatal clinic, antenatal home visits as well as the nursing care plan for client during the antenatal period.

2.1 FIRST CONTACT WITH CLIENT

Madam Alima was first met on Wednesday, 2nd December, 2020 at Dormaa West District Hospital around 10:00am, which was her ninth antenatal visit to the clinic. When she arrived, education on nutrition was ongoing so she sat down to listen and after the education, opportunity was given to ask question and she complained bitterly of experiencing loss of appetite which she did not experience during her previous pregnancies. She was educated that, each pregnancy is different and there are measures to manage these minor disorders. She was encouraged to eat in bit and at frequent interval and also to perform proper mouth care. Client was given multivitamin especially vitamin B complex to improve her appetite.

After going through her antenatal book, she fell within the criteria for selection as well. That is, client had good obstetrical history and was at her 36th week of gestation. Introduction was made and why client was chosen for care study was explained to her and she accepted to be selected for the study. She was then introduced to the Midwife-in-charge for her approval which she did. Explanations about the various examinations that will be done on her were given, her vital signs together with some laboratory investigations done on her were recorded as;

Temperature	36.1 degree Celsius
Pulse	82 beats per minute
Respiration	24 cycles per minute
Blood pressure	120/77 millimeter mercury
Weight	70 kilograms
Height	160centimeters
Hemoglobin level	13.2 grams per decilitre

Specimen bottle was given to Madam Alima to collect midstream urine to be checked for the presence of protein and glucose by the use of a urine reagent strip and the test read negative. Permission was sought from her for head to toe examination to be performed on her which she consented. All the necessary requirements needed for the examination were gathered and sent to the examination room, privacy was provided using a screen and also drawing down the curtains to make her feel comfortable after explaining the procedures. Having emptied her bladder, permission was sought for head to toe examination to be carried out and she granted.

She was assisted to undress and wrap herself with a cloth. She was helped to lie on the examination couch. Hands were thoroughly washed with soap under running water and dried with clean towel. She was asked to assume a dorsal position.

HEAD TO TOE EXAMINATION

Physical examination from head to toe was carried out under the supervision of the midwife in-charge and the aim was to help detect any abnormality or deviation from normal for prompt management.

On the head; Client's hair was neatly braided, lice and dandruff were absent on the scalp. There was no edema and rashes on the face or the eyelids. The sclera was checked for jaundice and the conjunctiva for pallor but none was detected. The nose and the ears were examined for pain and discharge but none was present. The lips were examined for dryness, pallor, sore and cracks but none was detected. There was absence of halitosis, the gum was inspected for bleeding which was absent and the tongue was neither pale nor coated. The neck was inspected and palpated for enlarged lymph nodes and distended veins but none was present.

On the chest; Both breasts were exposed and inspected for the size and shape and the condition of the skin which had no abnormality. One breast was covered and she was asked to put the hand of the part to be examined under her head. The breast was palpated and there were no masses, lump, cracks or sore nipple. The nipple was squeezed gently, cleaned with dry cotton wool swab and was examined for blood and any abnormal discharge but it was normal. Same procedure was performed on the other breast and no abnormality was detected. Client was educated and taught how to perform self-breast examination.

On the extremities; Inspection was done as to whether the upper extremities are equal or not, edema of the finger, capillary refil and pallor of the palms were present and no abnormality was detected. The lower extremities were also inspected for edema, equality, tenderness in the calf muscle and varicose veins but none was detected.

The back was also examined for the presence of any pain at the costovertebral angle, scoliosis, oedema of the sacral region and also the condition of the surrounding skin was noted and no abnormality was detected.

ABDOMINAL EXAMINATION

Inspection; The abdomen was medium in size and ovoid in shape. Linear Ingra was present and scars and striae gravidarum were absent.

Measurement of symphysio fundal height; The symphysiofundal height was measured in centimeters and a measuring tape was used in taking the measurement. The zero end of the tape measure was placed on the fundus of the uterus and the tape measure was extended to the upper boarder of the symphysis pubis and the symphysiofundal height was obtained as 35 centimeters.

Fundal palpation; Before performing the palpation, the palms were rubbed together to prevent induced contractions. Standing at the right hand side of the woman, the fundus was palpated with both palms and the buttocks of the foetus were felt occupying the upper pole of the uterus. The fundus was at the xiphisternum.

Lateral palpation; One hand was used to stabilize one side of the maternal uterus and the other hand was moved gently in a circular manner at the right side of the abdomen, the fetal back was palpated which was smooth. This was repeated at the left side of the abdomen and the limbs were palpated which were rough.

Pelvic palpation; Upon facing the lower limbs of the client at her right hand side, client was asked to flex her knees slightly and breathe through her mouth. Both hands were placed closely together and pointing downwards and inwards below the umbilicus, the presentation was cephalic as the head of the foetus could be balloted in between the two hands and the lie was

longitudinal with right occipito-anterior as foetal position.

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

Auscultation; A fetoscope was rubbed in the palms to make it warmed and was placed at the area where the back was located to listen to the foetal heart beat. Whiles listening to the heart beat, one hand was placed at the maternal radial pulse area to ensure that it's not the maternal pulse being listened to. The foetal heart rate was checked for one minute and recorded as 144 beat per minute.

VULVA EXAMINATION

Permission was sought to examine the genital area and she agreed. Hands were washed with soap and water and dried with a clean towel. Gloves were worn. The vulva was inspected for edema, scar, genital warts, rashes, ulcer of the vulva, discharges and varicose veins but none was present. The mons pubis was well shaved. Client was encouraged to continue practicing good vulva hygiene. Client was asked to assume lateral position and sit up before getting out of bed and was assisted to redress. All equipments used were decontaminated appropriately. The gloves were removed and also discarded. Hand washing was done and dried with clean dry towel.

All findings were recorded in client's antenatal book and communicated to her. Client was encouraged on good nutrition and exercise. She was asked not to lift heavy objects and avoid prolonged standing. She was encouraged to have enough rest and sleep. Client was given routine

drugs. The routine drugs given to client were;

Tablet ferrous sulphate200mg daily for 7 days

Tablet Folic Acid 5mg daily for 7 days

Tablet multivitamin 200mg daily for 7 days.

She was reminded of her date of next visit to the clinic which was 9th December, 2020. Client was asked to report to the clinic if any abnormality was observed. Appointment for home visit was scheduled for 3rd December, 2020. Direction to her house was taken and exchange of contacts was also done. She was followed to her house from the facility just to know where she lives.

2.2 FIRST ANTENATAL HOME VISIT

3rd December, 2020 was the first day Madam Alima was visited at 4:00 pm. The purpose of this first visit was to assess the client environment very well, source of water, ventilation, lighting system and also educate the woman on complication readiness. The journey was made by foot to the client's house using the directions given on the previous day when she was first met at the hospital. The house was far from the center. On arrival, client added that she now experiences less of the loss of appetite and was encouraged to continue maintaining oral care before and after meals. It was realized that Madam Alima lived in a rented boys-quarters, plastered with cement and roofed with aluminum sheets with six rooms containing a single hall with two other bed rooms and two toilet and two bathroom for all tenants. Madam Alima lives in a single hall and two bed rooms among the six. She has put up a metal structure which served as kitchen created in front of her room and with a cupboard in which she has neatly arranged her utensils. A warm welcome was given and pleasantries exchanged, introduction was made to the family members who were first met on that day and the purpose of the visit was announced. She was asked how

herself and the family were faring which she responded that they were all fine. She was asked whether she was doing something but she said she just finished cooking so the conversation could continue. During the interaction, it was identified that she sleeps in one of the room with her husband and her two kids occupies the other bedroom. The room was well decorated with flowers, nice carpets laid on the floor and curtains hanged on each window. The room was well kept, had adequate lighting and ventilation she was congratulated and asked to keep it up. She was asked whether the children slept under an insecticide treated bed net but she said no because the younger child has once complain to her that he is scared to sleep under mosquito net and that he feels he is caged. She was told to sleep beside her children for sometimes in other for them to get used to it and to take the fears out from him. She was again educated on the importance of sleeping under an insecticide treated net and encouraged find a carpenter to put some nails on the wall and also get a conical shaped insecticide treated bed net from the health facility so that during the evening she could hang it for the children to sleep under and early the next morning she could remove it up which she agreed. Permission was then asked to enter the next room where she and her husband slept. On inspection, client had some clothes hanging in the room. In client bedroom, there was a wooden bed with an insecticide treated net hanging loosely over it. She was encouraged to hang the mosquito net well, fold and pack the clean clothes nicely into their various bags and also not to hang any cloth whether dirty or neat on the nail since mosquitoes can hide in them. She was also encouraged to buy a laundry basket and keep the dirty clothes in them. However, the toilet and bathroom she used were well kept. A dustbin with a well-fitting lid was seen outside the house, which is emptied every day into the public refuse dump some few meters away from their house. According to the client, they fetch water from a nearby tap in their vicinity and stores it in a clean large bucket with a lid and have a good

drainage system. Client was asked to assemble her layette. The items were set and neatly folded in her bag (a hand bag). Some of the items included; sanitary pads, 4 cot sheets, 2 old cloths, 1 toilet roll, 2 carbolic soaps, 1 antiseptic solution (Dettol), 2 rubber mackintosh for delivery, baby's socks, cap and baby welcome. She was congratulated for keeping and arranging her layette neatly. Client was asked if someone will accompany her to the clinic to deliver and also the support person after delivery and she replied by saying her husband and sister in-law will take that responsibility. She was also encouraged to arrange with a driver to bring her to the clinic when labour sets in, because her house was far from the clinic as well as identify a blood donor who will donate blood for her when the need arose.

Madam Alima was educated on the importance of maintaining good personal hygiene and encouraged to continue with her medication. She complained of heartburns which was explained to her as a normal physiology in pregnancy. Education was given to relax for some minutes after eating before lying down to sleep. She was informed of the second visit to the house on 7th December, 2020. Client was thanked for her time and hospitability and permission was sought to leave.

2.3 SECOND ANTENATAL HOME VISIT

The second home visit to Madam Alima house was on the 7th of December, 2020 at 3:30pm. Client was met chatting with her sister in-law in the kitchen. The well-being of the family was inquired and she said they were all doing well by God's grace. A quick observation was made again on her surrounding which was neatly swept with utensils cleaned and arranged in the cupboard nicely. On entering her room, it was realized that, the nails for the net is been in- place and their bedroom has been arrange well and neat as taught earlier. She added that her son now sleeps in the net and he is no longer afraid and scared because of the education she gave to him

concerning people losing their lives because of malaria, especially children and also said she no longer experiences the heartburns. Client's sister in-law was going to be her birth companion and she had pack her delivery items with some amount of money and her insurance card as well as antenatal book. She was then congratulated and asked to keep it up. She was educated on true labour signs such as painful regular rhythmic uterine contractions and the appearance of show as well as danger signs such as blurred vision, bleeding, severe headache, severe vomiting and told to report to the clinic any time she sees any of those signs. She was allowed to ask questions and appropriate answers were given. Client was asked if she had any problems and she complained of having frequency of micturition. Emphasis was laid on the physiological changes and minor disorders in pregnancy. It was further explained to her that pressure from the descending head exerted on the bladder leading to the frequent urination. She was thanked for her cooperation and permission was sought to leave the house. Client was reminded about the next visit to the clinic which will be on 9th of December 2020 and she attended with no abnormality.

2.4 SUBSEQUENT VISIT TO THE CLINIC

Wednesday 9th December, 2020 was a week she was scheduled for her next visit to the clinic. Before her arrival to the clinic, a call was made to see if she is aware of her visit. On arrival, she was offered a seat, rapport was established and weight assessed which was 71 kilograms. Her vital signs were checked and recorded as:

Temperature	36.6 degree Celsius
Pulse	69 beats per minutes
Respiration	20 cycle per minute
Blood Pressure	110/66millimetre of mercury

Sample of her midstream urine was taken and checked for protein and glucose and they were all negative. All procedures to be carried on her were explained to her and privacy was provided. Hand washing was done with soap under running water and dried with a clean towel. She was assisted onto the examination bed, physical examination was done from head to toe and everything was normal.

On abdominal examination, the abdomen was seen to be ovoid and medium in size. Palpation was done and the fetal buttocks was located in the upper pole of the uterus whiles the back of the fetus was felt at the right side of the maternal uterus and the fetal limbs felt on the left side of the mother. The lie was longitudinal. The head occupied the lower pole and the descent checked was 5/5th. The symphysio-fundal height was 36cm with a fetal heart beat of 143 beats per minute and gestational age 37 weeks. Madam Alima was thanked for her co-operation, helped into a comfortable position followed by hand washing and all findings were communicated to her. Client was encouraged to maintain a straight back when even lifting light objects, also to get a hard board under her mattress for a firm back support and was also asked if there were any complains but she answered no. Client was encouraged to take her routine drugs as usual which included:

Tablet ferrous sulphate 200mg daily for 7 days

Tablet folic acid 5mg daily for 7 days

Tablet multivitamin 200mg daily for 7 days

Client was informed of her date of next visit to the clinic which was 16th December, 2020 and was accompanied to the road side and bid farewell.

2.5 THIRD ANTENATAL HOME VISIT

Madam Alima was visited to the house for the third time on 14th December, 2020 at 4:30pm. The purpose of the visit was to inquire about her health status and the condition of the family as well. Greetings were exchanged and a seat was offered as client looked cheerful on arrival. The well-being of the family was inquired and a positive response was given. Then enquiry about frequency of micturation was made and she said it has subsided .Client's environment was clean and tidy on inspection. She was asked if she had any problems and client complained of having itchy vulva. Emphasis was laid on the physiological changes and minor disorders in pregnancy. She was encouraged to apply a panty liner if possible and practice proper vulva hygiene. Client was reminded of her next visit to the clinic which was on the 16th of December, 2020. She was thanked for her cooperation and permission was sought to leave.

2.6 SUBSEQUENT VISIT TO THE CLINIC

Wednesday 16th December, 2020 was a week she was scheduled for her next visit to the clinic. Before her arrival to the clinic, a call was made to see if she is aware of her visit. On arrival, she was offered a seat, rapport was established and client added that the itchness of vulva has subsided, weight was assessed which was 72 kilograms. Client's vital signs were checked and recorded as:

Temperature	36.2 degree Celsius
Pulse	76 beats per minutes
Respiration	21 cycle per minute
Blood Pressure	108/60millimetre of mercury

Sample of her midstream urine was taken and checked for protein and glucose and they were all negative. All procedures to be carried on her were explained to her and privacy was provided. Hand washing was done with soap under running water and dried with a clean towel. She was assisted onto the examination bed, physical examination was done from head to toe and everything was normal.

On abdominal examination, the abdomen was seen to be ovoid and medium in size. Palpation was done and the fetal buttocks was located in the upper pole of the uterus whiles the back of the fetus was felt at the right side of the maternal uterus and the fetal limbs felt on the left side of the mother. The lie was longitudinal. The head occupied the lower pole and the descent checked was 5/5th. The symphysio-fundal height was 37cm with a fetal heart beat of 138 beats per minute and gestational age 38 weeks. All findings were communicated to her after the procedure and was thanked for her co-operation. She was encouraged on good sleep and rest and was also asked if there were any complains but she answered no. Client was informed of her date of next visit to the clinic which was 23rd December, 2020. Appointment for home visit was scheduled but permission was not granted as client explained that she will be travelling but was asked to be available on scheduled days for antenatal visit since the journey was far. She was accompanied to the road side and bid farewell.

2.7 FOURTH ANTENATAL HOME VISIT.

The fourth home visit to Madam Alima's house was 20th of December, 2020 at 4:00pm. The aim of the visit was to inquire about her health status and the general condition of the family. A positive answer was received from client after enquires were made and the whole family looked happy on arrival. Client was reminded on the true signs of labour such as appearance of the 'show', painful regular rhythmic uterine contractions as well as the danger signs such as severe

vomiting, blurred vision, severe headache and told to report to the clinic anytime she sees any of those signs. She was educated on good nutrition, rest, relaxation, sleep, and to perform simple exercises as long as she feels comfortable which her husband added that he will see to every activities and also support her as well. She was encouraged to take her routine drugs and avoid unprescribed drugs and concoctions. Client was reminded of her next visit to clinic which was on the 23rd of December, 2020.

2.8 SUBSEQUENT VISIT TO THE CLINIC

Wednesday 23rd December, 2020 was a week she was scheduled for her next visit to the clinic. Before her arrival to the clinic, a call was made to see if she is aware of her visit. On arrival, she was offered a seat, rapport was established and weight assessed which was 74 kilograms. Her vital signs were checked and recorded as:

Temperature	36.5 degree Celsius
Pulse	72 beats per minutes
Respiration	22 cycle per minute
Blood Pressure	120/81millimetre of mercury

Sample of her midstream urine was taken and checked for protein and glucose and they were all negative. All procedures to be carried on her were explained to her and privacy was provided. Hand washing was done with soap under running water and dried with a clean towel. She was assisted onto the examination bed, physical examination was done from head to toe and everything was normal.

On abdominal examination, the abdomen was seen to be ovoid and medium in size. Palpation was done and the fetal buttocks was located in the upper pole of the uterus whiles the back of the fetus was felt at the right side of the maternal uterus and the fetal limbs felt on the left side of the mother. The lie was longitudinal. The head occupied the lower pole and the descent checked was 5/5th. The symphysio-fundal height was 38cm with a fetal he art beat of 145 beats per minute and gestational age 39 weeks. All findings were communicated to her after the procedure and was thanked for her co-operation. Client was reminded of her date of next visit to the clinic which was 30th December, 2020. She was encouraged to report to the clinic whenever abnormalities are been detected. Client was encouraged to maintain good nutrition, sleep and rest and was asked if there were any complains but she said no. She was accompanied to the road side and bid farewell.

2.9 NURSING CARE PLAN

PROBLEMS IDENTIFIED DURING ANTENATAL

On the 2nd December, 2020, client complained of:

1. Loss of appetite

On the 3rd December, 2020, client complained of:

2. Risk for infection (malaria)

On the 3rd December, 2020, client complained of:

3. Heartburns

On the 7th December, 2020, client complained of:

4. Frequency of micturation

On the 14th December, 2020, client complained of:

5. Itchy vulva

SHORT TERM OBJECTIVES

1. Client's appetite will improve within 48 hours.
2. Client will be free from infection within 2 hours.
3. Client will be relieved of heartburns within 24 hours.
4. Client will be able to understand and cope with frequency of micturition within 12hours.
5. Client itchy vulva will be resolved within 48 hours.

LONG TERM OBJECTIVE

Madam Alima will go through pregnancy successfully without any complication to both mother and baby.

ANTENATAL CARE PLAN FOR MADAM ALIMA

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
02/12/20 @ 10:00am	Loss of appetite related to hormonal changes in pregnancy.	Client's appetite will improve within 48 hours as evidenced by 1. Client verbalizing she is able to eat half of a plate served. 2. Relative observing that client can now consume 2/3 of meal served.	1. Reassure client of competent care. 2. Educate client on the effect of under nutrition on pregnancy. 3. Encourage client to maintain oral care before and after meals. 4. Plan diet with client taking into account her preferences. 5. Encourage client to eat more fruits, vegetable and high fiber for easily digestion. 6. Encourage client to take her routine drugs to stimulate her appetite.	1. Client reassure of competent nursing care. 2. Client understood that under nutrition could affect labour process. 3. Client was encouraged to rinse her mouth before and after eating. 4. Client's diet was planned with her taking into account her preferences. 5. Client included fruit like orange and mangoes to her diet. 6. Client understood the important of taking her routine drugs as prescribed.	04/12/20 @ 10:00am	Goal was fully met as; 1. Client verbalized she was able to eat half of a plate served. 2. Relative visualizing that client can consume 2/3 of meals served.	A.G

ANTENATAL CARE PLAN FOR MADAM ALIMA

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
03/12/20 @ 4:00pm	Risk for infection (malaria) related to inadequate knowledge on effect of malaria on the children.	Client will gain adequate knowledge, effects and prevention of malaria within 2 hours as evidenced by: 1. Client verbalizing that children now sleeps under treated mosquito net. 2. Midwife visualizing that children now sleeps under treated mosquito net during the subsequent visits.	1. Clear misconception on the use of insecticide mosquito net. 2. Educate client on the effects of malaria on children. 3. Educate client on the signs and symptoms of malaria. 4. Encourage client to mount Long Lasting Insecticide net 5. Educate client on the prevention of malaria.	1. Client was assured that when nets are been mounted children will be able sleep under the mosquito net. 2. Client was taught that malaria could make children anaemic and kills them. 3. Client is enlighten that fever, chills, nausea, vomiting etc are signs of malaria. 4. Client mounted Long Lasting Insecticide net. 5. Client should clean the environment of weds and stagnant.	03/12/2020 @ 6:00pm	Goal fully met as evidenced by: 1. Client verbalizing that children slept under treated mosquito net 2. Midwife visualized that children sleeps under treated mosquito net.	A.G

ANTENATAL CARE PLAN FOR MADAM ALIMA

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
03/12/20 @ 4:00pm	Heartburns related to regurgitation of gastric content into the oesophagus.	Client's heartburns will resolve within 24 hours as evidenced by: 1. Client verbalizing she is relieved of the burning sensation. 2. Midwife observing client expressed no sign of burning sensation.	1. Educate client on the physiology of heartburns. 2. Encourage client to sit for some time before lying down to sleep after eating. 3 .Encourage client to reduce intake of spices, oil and fats 4. Encourage client to eat food in bit and at frequent intervals. 5. Encourage client to sleep with extra pillows. 6. Reassure client of competent nursing care	1. It was explained to client that heartburns is physiological and it will resolved on its own. 2. Client relaxed some hour after eating before going to bed. 3. Client reduce the intake of spices and oil in her meals. 4. Client eat food in small quantity. 5. Client supported with extra pillows to elevate her head preventing back flow of food. 6. Client was reassured that she is in good hands.	04/12/20 @ 4:00pm	Goal fully met as evidence by: 1.Client verbalizing that she is relieved of the burning sensation 2. Midwife observing that client expressed no sign of burning sensation as client have a relaxed facial expression.	A.G

ANTENATAL CARE PLAN FOR MADAM ALIMA

DATE /TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
07/12/20 @ 3:30pm	Frequent micturation related to foetus exerting pressure on bladder in late pregnancy.	Client can cope with frequent micturation within 2 hours as evidenced by: 1. Client verbalizing that she can cope with the condition. 2. Midwife visualizing that client no longer complain.	1. Reassure client that the condition is temporal. 2. Educate client on the physiology of frequent micturation 3. Educate client to reduced intake of fluid containing natural diuretics like tea and coffee 4. Encourage client to bend forward when urinating so that the bladder will be empty. 5. Encourage client to keep chamber pot in her bed room.	1. Client was assured that the condition will subside after delivery. 2. Client is now aware that it due to the pressure from the presenting part. 3. Client reduced the intake of fluids such as tea, coffee etc. 4. Client was bending forward when urinating. 5. Client chamber pot was kept closer to her.	07/12/20 @ 5:30pm	Goals met as; 1. Client verbalized that she is coping with frequent micturation. . 2. Midwife visualized that client no longer complains.	A.G

ANTENATAL CARE PLAN FOR MADAM ALIMA

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
14/12/20 @ 3:30pm	Itchy vulva related to poor perineal care	Client will be free from itchy vulva within 48 hours as evidenced by: 1. Client reporting no signs of itchness. 2. Midwife witness no sign of infection such as pyrexia.	1. Reassure client that the condition can be managed. 2. Educate client to ensure good vulva hygiene. 3. Encourage client to wear loose underwear to allow ventilation. 4. Educate client to wash and dry her panties in the sun.	1. Client is assured of been in competent hands. 2. Client was using panty liner and was cleaning herself from anterior to posterior frequently. 3. Client was encouraged to wear cotton panties and underwear. 4. Client was washing and drying her panties directly in the sun to kill harbored bacterial.	16/12/20 @ 3:30pm	Goal fully met as evidenced by; 1. Client reported no sign of itchiness. 2. Midwife witnessed no sign of infection such as pyrexia	A.G

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

This chapter describes the management of labour and immediate care of the newborn, subsequent care, examination of the newborn and care plan drawn for the management of the problems encountered during the labour period.

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR.

On 29th December, 2020, Madam Alima reported to the clinic around 1:40pm with her husband and sister in-law. Rapport was established and they were offered seats. Client was taken to the nurses' station for necessary information to be taken while glancing through her antenatal card. She was asked if she had experienced any danger signs as discussed earlier but Madam Alima replied that she had not seen any of those signs. Client and her sister in-law appeared anxious and they were told that she is in competent hands and that we will ensure she has a safe delivery.

Madam Alima said she could feel the fetal movement and has severe lower abdominal pain with painful rhythmic contraction which started at 10:30am the day before and has also noticed the appearance of 'show'. An enquiry about her last meal was made and she said she took rice and stew around 6:30pm and moved her bowel before going to bed. She was asked if she had taken any medication or herbs since pain started but she answered negative. Madam Alima was sent to the examination room around 1:50pm and assisted to change her clothing. Permission was sought to examine her and all procedures were explained to her. She was then asked to pass urine and her urine measured 100mls, the sample was tested for albumin, sugar and acetone but the results

were negative. Client was assisted to lie on the couch and a quick examination from head to toe revealed no abnormality. Her vital signs were checked and recorded as follows:

Temperature - 36.5^{o}C

Pulse - 69 beat per minute

Respiration - 22 cycle per minute

Blood pressure - 130/80 mmHg

Abdominal examination was then carried out after privacy was provided. On inspection the shape of the abdomen was ovoid and straie gravidarum, linear nigra and fetal movement were noticed. Fundal, lateral and pelvic palpations were performed. The symphysio-fundal height was 38 cm while gestation was exactly 39+6days weeks, the lie was longitudinal, and presentation was cephalic. The descent of the head was 4/5thand uterine contraction was 3 in 10 minutes lasting 19seconds. On auscultation, fetal heart rate was 130 bpm with good volume and regular rhythm.

VAGINAL EXAMINATION

A sterile tray for vaginal examination was brought to the bed side and the procedure was explained to her. Hands were washed and dried and sterile gloves worn. The vulva was inspected for rashes, varicose veins, warts, scars and oedema but none was present. The vulva was swabbed with savlon solution, using sterile swabs, the labia majora was swabbed with two sterile cotton wool soaked in savlon solution, the labia minora was also swabbed the same way and a single cotton wool soaked in savlon solution was used to swab the vestibule after which vaginal examination was carried out.

The vagina felt moist, warm and distensible. The cervix was thin, soft, effaced and the presenting part well applied to it. The cervical dilatation was 4cm with membranes intact. No moulding was found. The sacral promontory was not reached at 11cm. the sacrum was well curved and the ischial spines were blunt. She was asked to lie on her side and a fist was made into the intertuberous diameter and it accommodated all the four knuckles. Client was cleaned after the examination and a clean perineal pad was applied to the vulva. Client was tidied up and encouraged to lie on her left side. All findings were explained to her and reassured that labour was progressing well. All procedures were done under the supervision of the midwife-in-charge and findings were recorded and plotted on a partograph around 2:00pm.

PREPARATION FOR BIRTH

In preparing for birth, a skilled and an unskilled helpers were identified. The first skilled helper was the Midwife-in-charge who was consulted to see to the delivery process and to give a helping hand. The unskilled helper was the client's sister in-law. The Physician Assistant was informed that there was a client in labour so in case of any emergency, he will be consulted. Client's sister in-law was also asked to contact the taxi driver to be alert in case there is the need for a referral (advanced care).

The area for delivery was prepared. Madam Alima was assisted and encouraged to wash her hands. She was informed her abdomen will be cleaned to prepare for skin-to-skin care prior to the second stage of labour and was also reminded that baby will be delivered onto her abdomen. Client was also informed that windows and doors will be closed and curtains drawn when labour was near to provide privacy and also to provide warmth for receival of the baby. A portable lamp was made available to assess the baby in case of light off. The area for ventilation was also prepared and the equipment was checked. A dry, flat and safe space was prepared to provide

ventilation if needed. The functions of the equipment were tested. Delivery set and emergency drugs all ready for use were available.

3.2 MANAGEMENT OF FIRST STAGE OF LABOUR

After the initial assessment, the foetal heart rate, contractions and maternal pulse were monitored every 30 minutes until she delivered. Vaginal examination, descent, cervical dilatation, maternal blood pressure and temperature were also repeated 4 hourly. She was encouraged to empty her bladder whenever she felt the urge to. According to client, she preferred walking inside the labour ward which she was permitted. Client was asked whether there were any other complaints and client complained of fatigue at 4:00pm and was seen sweating profusely at 4:10pm. She was served with a glass of water and sweat was wiped with damp towel to make her comfortable. She further added that she did not know what the outcome of her labour is going to be like. Client was reassured of safe delivery with a healthy baby without any complications after delivery. Client was educated not to touch her perineal pad unnecessarily. Client was encouraged to breathe through her mouth when there was contraction and also avoid pushing during contraction since the cervix was not fully dilated to prevent oedematous cervix. Bedpan was provided for her to empty her bladder frequently to enhance effective contraction and descent of the foetal head since full bladder could slow down the progress of labour. Client was educated on the importance of changing the pad when soiled. She was encouraged to take in sips of water in order to stay hydrated. Client was offered pineapple drink in order to boost her energy for effective pushing during the second stage of labour.

At 6:00pm vaginal examination was repeated, vulva was normal, vagina was warm and moist, cervical os was 8cm dilated, cervix thin, soft and elastic, membranes were intact with moulding was (+) which indicated that the parietal bones were in apposition . The descent of the head was

1/5th. Contractions were 3 in 10 minutes lasting for 45 seconds, fetal heart rate was 140bpm and maternal pulse was 84bpm, blood pressure 130/70mmHg and temperature 36.3°c whilst urine measured 75mls and protein and acetone tested negative and was closely monitored and managed on the partograph throughout the first stage of labour. Client requested for cold drink as she complained of dry throat and was served with malt. Hands were washed thoroughly with soap and clean water and a delivery trolley was set with the following items:

Top shelf

The top shelf consisted of sterile items which are;

1. A pair of scissors.
2. Two artery forceps.
3. Towels.
4. A receiver for placenta.
5. Two gallipots.
6. Episiotomy pack

Bottom shelf

4. A drum containing gauze and cotton wool.
5. Measuring jug.
6. Urethral catheter and drainage bag.
7. Examination gloves.
8. Sterile gloves
9. Cot sheets.
10. Cord clamp.

11. Identification band.
12. Bed pan.
13. Receptacle for soiled linen.
14. Swabbing lotion.
15. Fetoscope.
16. Xylocaine.
17. Water for injection and perineal pads.

Oxygen and suction machine were all in good working condition, as well as mackintosh apron, boots and goggle were made ready for delivery. Client was informed that the baby would be delivered onto her abdomen to establish bonding. She was helped to wash her hands and the abdomen was cleaned with savlon solution.

Madam Alima complained of severe bearing down sensations with the uterine contraction becoming more expulsive and frequent. A quick examination of the perineum revealed, vulva and anus gaping, perineum was bulging and a trickle of blood was seen. At 7:40pm, membranes ruptured spontaneously with clear liquor and vaginal examination was done again and the cervix was fully dilated (10cm). Descent was $0/5^{th}$, moulding was two plus (++) which indicated that the bones were overlapping each other but could slip off, contractions were four (4) in ten (10) minutes lasting forty five(45) seconds. Foetal heart rate was 144 beats per minute. The Midwife-In-Charge was called to confirm if really cervix is fully dilated and it was true. Findings were recorded on the partograph sheet and client was informed of the full dilatation of the cervix. Client was informed that the baby would be delivered onto the abdomen to establish bonding. Client was encouraged to push with contractions and rest in between contractions.

3.3 MANAGEMENT OF THE SECOND STAGE OF LABOUR.

Madam Alima was transferred to the second stage room. What is expected of her during the delivery was explained to her including the various positions for delivery and she preferred the lithotomy position. Madam Alima was then assisted to assume that position. She was reassured and every procedure to be done was explained to her. Protective clothing such as mackintosh apron, rubber boots and goggles were worn. Hands were washed with soap under running water and dried with sterile towel and sterile gloves were worn on both hands. The vulva and the upper thigh were swabbed with savlon solution and client draped with sterile towels. She was reminded that her baby will be delivered unto her abdomen to provide warmth and improve bonding. The delivery trolley and instrument were checked.

A clean perineal pad was applied to the anus to keep the delivery area clean. Madam Alima was encouraged to push with each contraction and rest in between contractions.

As labour progressed, the head advanced gradually and flexion was aided by gently pressing the occiput downwards in other to allow the smallest diameter of the skull to distend the vulva and the perineum. Descent of the fetal head continued till crowning of the head occurred, Madam Alima was asked to stop pushing and pant at this stage to prevent rapid expulsion of the head which could lead to perineal tears and intracranial injury. The sinciput, face and chin swept the perineum and the head was slowly delivered by extension to prevent tear and injury to the baby. The eyes were cleaned with separate sterile swabs from the inner cantus of the eye outwards. The mouth and nose were cleaned with gauze. The cord was quickly felt for around the baby's neck but there was none. Client was asked to stop pushing and pant with contractions.

The head was supported and restitution was allowed to take place, followed by external rotation of the head indicating internal rotation of the shoulders, as this movement brought the shoulders into the anterior-posterior diameter of the pelvic outlet. Madam Alima was asked to push with the next contractions. Both palms were placed on either side of the baby's ear and the head was gently pressed downwards to deliver the anterior shoulder which escaped under the symphysis pubis. The posterior shoulder swept the perineum and was delivered. The rest of the body was delivered by lateral flexion unto the mother's abdomen at 8:02pm. An alive healthy male baby was delivered who cried lustily after delivery. Madam Alima was congratulated for her effort and co-operation. Liquor was quickly wiped off baby's body. Baby was put on mother's abdomen and covered with a cot sheet and sterile towel, to promote skin to skin contact.

3.4 IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, the eyes were cleaned with sterile gauze. The baby cried immediately after birth. Mouth and nose were cleared and to prevent aspiration of secretions. Baby was cleaned off liquor with a cot sheet and replaced with a warm dry one. The umbilical cord was clamped 2cm away from the baby's abdomen and about 3cm from the first clamp. The umbilical cord was covered with gauze and cut in between the clamps with a pair of sterile scissors to avoid splashing of blood from the cord. The baby was separated from the mother and skin to skin care with the mother was allowed for an hour. Breastfeeding was initiated during skin to skin care. An identification band bearing mother's name, baby's sex, time and date of delivery was placed on baby's wrist to differentiate him from other babies. The baby was assessed according to the APGAR score at the first and fifth minute after birth. The first minute APGAR score was recorded as follows;

Appearance	2
Pulse	2
Grimace	1
Activity	1
Respiration	2
Total	8/10

The fifth minute APGAR was also recorded as

Appearance	2
Pulse	2
Grimace	1
Activity	2
Respiration	2
Total	9 /10

The baby was left in skin to skin contact on mother's chest providing warmth and also promoting bonding. The mother was asked to hold the baby on her abdomen as management of the third stage began.

3.5 ACTIVE MANAGEMENT OF THE THIRD STAGE OF LABOUR

After the cord separation, a sterile receiver was placed near the vulva in between the thighs to receive the end of the cord. Client's abdomen was palpated to rule out any second foetus in utero before 10 units of oxytocin was given intramuscularly at 8:03pm by the midwife-in-charge to enhance contractions and also to prevent any bleeding. Then client was asked to empty her bladder and she said she had no urge so the cord was reclamped closer to the vulva. The left hand was placed on the fundus to feel for contractions. As soon as contractions were felt, the clamp was held with the right hand while the left hand was placed on the lower abdomen in the suprapubic area with palms facing the umbilicus. The right hand which held the clamped cord, was used to apply gentle downward traction in a downward direction, counter-pressure was maintained with the left hand on the suprapubic area while controlled cord traction is also maintained until the placenta was visible at the vulva. Both hands were used to receive the placenta at the introitus and placed in a bowl at 8:08pm.

The uterus was massaged to maintain the contraction. Client was thought to massage her uterus and she was asked to feel the hardness of the uterus which indicated that the uterus was well contracted. This procedure was done every 15minutes for two hours making sure the uterus was firm, while blood loss was checked. A quick assessment of the placenta was made, and all the lobes were complete and healthy. The uterus was massaged and blood clots were expelled. Perineum, vaginal walls and cervix were examined under a light source and there were no tears.

The blood loss was 100mls. Client was cleaned and a new perineal pad was placed at the perineum to make her comfortable in bed. Client was encouraged to change her pad and urinate frequently to prevent post-partum hemorrhage and infections. She was also educated on the need

to ensure the contractions of the uterus. Client was thanked and congratulated for her cooperation.

3.6 EXAMINATION OF PLACENTA AND MEMBRANES

After client was made comfortable in bed, the placenta was examined thoroughly in the sluice room. The placenta was placed in 0.5% chlorine solution and then held by the cord with the membranes hanging and the membranes were examined for completeness and it was intact. The placenta was then laid on a flat surface for further examination. The amnion was peeled from the chorion up to the umbilical cord and was fully viewed, the lobes fit together without any gab and edges also forming uniform circle at the maternal surface and this meant that there was no missing lobe, there was no white patches (infart) on the maternal surface, there was also no blood vessels radiating into the membranes which meant no succenturiate lobe. The cord was situated at the center of the placenta with one vein and two arteries surrounded by the Wharton's jelly. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility. The instruments and equipment's used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization. Hands were dipped in chlorine solution before discarding the gloves. The findings were recorded on the labour sheet, delivery book and summary of delivery in the antenatal booklet. The partograph was completed.

3.7 MANAGEMENT OF FOURTH STAGE OF LABOUR

This is the period of six hours after delivery of the placenta during which both the mother and baby are under continuous observation in order to detect early complications, Madam Alima and her baby were monitored for six hours before transferring them to the lying-in-ward. The support

person and husband were informed about the safe delivery and sex of the baby that is a boy, for which they accepted and were very happy. They expressed gratitude for the patience and care.

Mother

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

Temperature - 36.4^{o}C

Pulse - 70 beat per minute

Respiration - 22 cycle per minute

Blood pressure - 120/70 mmHg.

Madam Alima was asked to empty her bladder frequently in order to help contractions of the uterus. Client was served with warm beverage and also encouraged to establish bonding and to maintain lactation. She was educated on how breastfeeding enhances the release of oxytocin which would improve uterine contractions, drainage of lochia, control of haemorrhage and also as a form of family planning.

Madam Alima was examined from head to toe. Her conjunctiva was pink and no abnormality detected. Uterus was well contracted and symphysio-fundal height was 16cm, there was no active bleeding from the vagina. She was encouraged to report if she saw any profuse bleeding. She was asked to change her pad when soiled in order to prevent infection. Madam Alima was served with vitamin A and the second dose was given on the following day. Madam Alima's vital signs and uterus were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and then hourly for three hours and findings recorded on the partograph. The findings were within the normal range.

Baby

Prevention of diseases (prophylaxis for the baby)

The following procedures were performed to prevent serious infection to the eye, cord and also prevent haemorrhagic disease of the newborn. Two (2) drops of Gentamycin eye drop was instilled on each eye, the umbilical cord was dressed with Chlohexidine gel. Vitamin K 1.0mg intramuscularly was given to the baby after head to toe examination was done. Baby's skin was smeared with baby oil to conserve heat. Hands were washed with soap under running water and cleaned with dry towel.

Examination of the new born

After washing hands and drying them, the procedure was explained to Madam Alima. Disposable gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, with nearby windows closed and light switched on. Baby was placed on a covered flat surface with only the part being examined exposed systematically. Baby's general condition was stable, baby's skin color was pinkish with no rashes. A detailed head to toe examination was carried out to determine any abnormality.

The head and face: The head was examined for softness/tension of fontanelles, size and shape, lacerations, caput succedaneum as well as intracranial haemorrhage but no abnormality was detected. Head circumference was measured by encircling the head with a tape measure from the occipital protuberance to the supra-orbital ridges and it measured 33cm. The eyes opened spontaneously when the baby was held in an upright position and the conjunctiva was clear. Eyes were also examined for color, redness, discharge, placement and conjunctiva for haemorrhage but no abnormality was found. The nose was inspected for size and shape and examined for

deviated septum but the septum was normal. The nostrils were inspected for patency and discharges and the mucosa for color and polyps which were all normal. The mouth was examined by pressing the angle of the jaw which opened the mouth and the tongue, gum and palate were inspected and there was no false tooth noticed. The palate was high arched, intact and the uvula centrally placed. There was no cleft palate or cleft lip, tight frenulum or tongue tie. Suckling, rooting and swallowing reflexes were checked and were present. The ears were inspected, the upper notch of the pinnae was at the same level with the canthus of the eye. External auditory meatus was patent and the cartilage in the pinnae was checked for it softness. The shape and size was also noted and no abnormality was detected.

Neck: The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good.

Chest and abdomen: The chest was examined, the respiratory movement was regular and the respiratory rate was 40cpm. Breasts were palpated for consistency, masses, and the nipples for position and engorgement. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord and no signs of infection. The cord was examined and there was one vein and two arteries. The liver, spleen and bladder were palpated for size, tenderness and masses but no abnormality was detected. Apex beat was present and recorded 136bpm when ausculted.

Limbs and digits: The length, movement and paralysis of the upper limbs were also noted. The digits were counted to be normal and separate to exclude webbing and the palm for the number of palmer creases. The shape and colour of the nail bed were inspected and reflexes (grasping, Moro) checked. Everything was normal. With the lower limbs, the leg and feet were inspected for symmetry, extra digits, webbing, movement, fare foot adduction, clubbed feet, knock-knees,

bowed leg, tibia torsion and paralysis but no abnormality was found. The hip had no dislocation and the reflexes (knee jerk/ patella, plantar) were present. The feet were examined for any disability such as talipsequinovarus. The groin and popliteal spaces were examined without any abnormality detected.

Back: The spine was also examined with baby turned to one side. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida and for missing vertebra, meningomyelocele but no abnormality was detected.

Genitalia and anus: The penis was inspected for epispadias and hypospadias then urethra was inspected for patency and descent of the testicles into the scrotal sac. The anus was examined for patency and it was patent. The anus was also palpated for sphincter tone, masses, tenderness but it was normal. The baby passed meconium and urine.

Baby's length was measured to be 51centimetres, weight was 3.5kg and temperature was 36.4◦C.

In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby continued. Gloves were removed and disposed aseptically before washing hands with soap under running water and dried with clean dry towel. The baby's skin was smeared with baby oil and wrapped. Vital signs and other assessment checked were communicated to mother and documented as:

Head circumference	-	33cm
Full length	-	51cm
Weight	-	3.5kg
Apex heart beat	-	136bpm

Temperature - 36.4 ^{o} C

Respiration - 40cpm

3.8 SUMMARY OF LABOUR

Client was admitted to the ward with complaints of labour pains on 29th of December, 2020 at 1:40pm. Labour progressed normally and client had spontaneous vaginal delivery of a live male child at 8:02pm. Active Management of Third Stage of Labour was done. Perineum was intact and blood loss was small (100mls). Condition of baby was very good as well as mother. The placenta and its membranes were delivered at 8:08 pm by controlled cord traction with perineum intact. Duration of labour under my care:

1st stage - 5 hours 40 minutes

2nd stage - 22 minutes

3rd stage - 6 minutes

Total - 6 hours 8 minutes

CONDITION OF BABY AT BIRTH

Sex - Male

Weight - 3.5kg

Full Length - 51cm

Head circumference - 33cm

APGAR - 8/10, 9/10

Temperature - 36.4^{o} C

Apex beat	-	136bpm
Respiration	-	40cpm
Urine	-	passed
Meconium	-	passed

The general condition of the baby was good.

CONDITION OF MOTHER

Perineum	-	Intact
Blood loss	-	100 mls
Temperature	-	36.4^{o}C
Pulse	-	70 bpm
Respiration	-	22 cpm
Blood pressure	-	120/70 mmHg
Fundus	-	16 cm
Lochia	-	Red (rubra)
Odour of Lochia	-	Non – offensive

Condition of mother after delivery was satisfactory.

CONDITION OF PLACENTA AND MEMBRANES

Placenta delivered	-	8:08 pm
Lobes and membranes	-	Complete and healthy
Maternal surface	-	Normal
Fetal surface	-	Normal

3. 9 NURSING CARE PLAN ON LABOUR

PROBLEMS IDENTIFIED

On the 29th December, 2020, client complained of:

1. .Lower abdominal pains.
2. Anxiety.
3. Waist pain.
4. Fatigue.
5. Risk for dehydration

SHORT TERM OBJECTIVES

1. Client will cope with lower abdominal pain within 6 hours
2. Client's anxiety will resolve within an hour.
3. Client will be relieved from waist pain within 30 minutes.
4. Client will be less tired within an hour.

5. Client will maintain her hydration level within 4 hours.

LONG TERM OBJECTIVES

Madam Alima will go through labour and puerperium successfully without any abnormality or complications to both mother and baby.

LABOUR CARE PLAN FOR MADAM ALIMA

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
29/12/20 @ 10:30am	Lower abdominal pain related to painful uterine contractions.	Client will cope with lower abdominal pain within 6 hours as evidenced by 1.Client verbalizing she is coping with the pain 2. Midwife observing a relaxed facial expression.	1. Reassure client and explain physiology to her. 2. Give client a sacral massage to relieve pain. 3. Encourage her to adopt a comfortable position. 4. Encourage and supervise client to do deep breathing exercise during contractions. 5. Provide diversion therapy.	1. Physiology was explained to her that, the pain was resulting from the strength and frequency of uterine contractions in the active phase of labour. 2. Sacral massage was given to client whenever there were contractions. 3. Client agreed to lie on her left side. 4. Client performed deep breathing exercises with contractions. 5. Client was engaged in conversation during labour.	29/12/20 @ 4:30pm	Goal was fully met as 1.Client verbalized that she was coping with the pain 2. Midwife observing client shows a relaxed facial expression.	A.G

LABOUR CARE PLAN FOR MADAM ALIMA

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
29/12/20 @ 1:40pm	Anxiety related to unknown outcome of labour.	Client's anxiety will resolve within an hour as evidenced by; 1. Client verbalizing she is no longer anxious of the outcome of labour. 2. Midwife observing client express herself in a calm manner.	1. Reassure client that she will deliver safely. 2. Explain to client the stages of labour. 3. Allow client to ask questions and answer appropriately. 4. Communicate findings to client. 5. Be with client throughout labour and give emotional support.	1. Client was reassured and introduced to other clients who has undergone successful spontaneous vaginal delivery. 2. Stages of labour were made known to her as it progresses and was thought into details to her. 3. Client was encouraged to ask questions and answers were duly provided. 4. All findings were communicated to her such as cervical dilatation and fetal heart rate. 5. Midwife stayed with client throughout labour while reassurance was continuously given.	29/12/20 @ 2:40pm	Goal was fully met as; 1. Client expressed a relaxed face and verbalized that she is relieved. 2. Midwife observing client express herself calmly.	A.G

LABOUR CARE PLAN FOR MADAM ALIMA

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
29/12/20 @ 7:40pm	Waist pains related to pressure exerted by presenting part at the sacral region.	Client will cope with waist pains within 30 minutes as evidenced by; 1. Client verbalizing she is coping with waist pains. 2. Midwife observing client complaining less of waist pains.	1. Reassure client that pain is temporal. 2. Educate her on the physiology of waist pain during labour. 3. Massage client's sacral region 4. Educate her to assume a comfortable position 5. Encourage deep breathing exercise.	1. Client was reassured that the waist pains will be relieved and that it is temporal. 2. Client knows that the waist pains is as a result of the pressure from the fetal head into the pelvis and on the bladder. 3. Client sacral region was massaged. 4. Client assumed the left lateral position. 5. Client was deep breathing exercise.	29/12/20 @ 8:10pm	Goal fully met as; 1. Client verbalized she is coping with waist pains. 2. Midwife observed client complained less of waist pains.	A.G

LABOUR CARE PLAN FOR MADAM ALIMA

DATE AND TIME	NURSING DIAGNOSIS	NURSING OUTCOME AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
29/12/20 @ 4:00pm	Fatigue related to the stress of labour.	Client will be relieved of fatigue within an hour as evidenced by 1. Client verbalizing that she feels relieved. 2. Midwife observing that client is refreshed and shows no signs of tiredness.	1. Reassure client to make her calm. 2. Explain to her why she feels tired. 3. Encourage client to rest in between contractions. 4. Encourage deep breathing exercises along contractions. 5. Encourage client to take in diet containing carbohydrates to give her energy.	1. Client was reassured of safe delivery. 2. Client is aware that, it is because she is not resting. 3. Client understood to rest in between contractions to prevent further exhaustion. 4.Deep breathing exercises was practiced 5. Client took mashed kenkey to give her more energy.	29/12/20 @ 5:00pm	Goal fully met as; 1. Client verbalized that she now feels relaxed. 2. Midwife observed that client was refreshed and shows on signs of tiredness.	A.G

LABOUR CARE PLAN FOR MADAM ALIMA

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
29/12/20 @ 4:10pm	Risk for dehydration related to the excessive sweating.	Client will remain hydrated throughout the period of labour and delivery as evidenced by; 1. Client making conscious effort to sip water every 30 minutes. 2. Midwife recording normal vital signs	1. Assess for signs and symptoms of dehydration. 2. Encourage copious fluid intake 3. Serve fluid nourishing diet. 4. Educate patient on fluid needs during labour. 5. Assess the vital signs regularly.	1. Features for dehydration were absent. Client had good skin turgor, moist skin and mucus membrane, and reported no thirst. 2. Client took in 300mls of orange juice every hour. 3. Client took 250mls of light soup during the process of labour. 4. Client was educated on fluid needs to aid pushing during labour. 5.Client BP, pulse and respirations were monitored	29/12/20 @ 8:10pm	Goals fully met as; 1. Client verbalized she is able to sip water every 30 minutes. 2. Midwife observing client has normal BP, pulse and respiration.	A.G

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter describes the management of both mother and baby from day one to six weeks postpartum and care plan drawn for the management of problems encountered during puerperium.

4.1 DAY OF DELIVERY

Madam Alima delivered on 29th December, 2020 at 8:02pm to a live male baby. Client and baby were transferred to the lying-in ward at 9:20pm after one hour of continuous skin to skin care. They were closely observed for six hours postpartum till their conditions were satisfactory. Client's immediate post-delivery vital signs were recorded as follows;

Temperature	36.4^0C
Pulse	70bpm
Respiration	22cpm
Blood Pressure	120/70 mmHg

On palpation the uterus was well contracted and the symphysio-fundal height measured 16cm above the symphysis pubis. The lochia was red in colour and flow was moderate. Vital signs were checked every 15 minutes for 2 hours, 30 minutes for 1 hour and hourly for the last 3 hours .On examination, no abnormality was detected. Client was encouraged to change the sanitary pad when wet to avoid the risk of infection and for comfort. Madam Alima was encouraged to report any bleeding per vaginum and also to urinate frequently to enable the uterus to contract firmly. Emphasis was placed on fluid and adequate diet to help replace worn out tissues and promote growth. Client was given vitamin A capsule 200,000 international units orally which will help

the baby to have a good eye sight, grow, build immunity and develop well. At 11:20pm, client complained of experiencing pain at her lower abdomen (after pain). Client was reassured and it was explained that suckling brings about the pain and it will help in the involution of the uterus so she should continue to breastfeed the baby and it will subside as time goes on. Client was educated to breastfeed baby exclusively and on demand and wash hands before and after breastfeeding baby. Client was served with 1g of tablet paracetamol to relieve the pain. Madam Alima's sister-in law prepared milo and bread for her after which client rested. The baby's vital signs were as follows;

Temperature 36.4^0C

Respiration 40cpm

Apex beat 136bpm

The cord was observed but there was no bleeding. Baby was put to breast and she suckled effectively.

4.2 SUBSEQUENT CARE OF THE BABY

Baby bath and cord dressing

After six hours of delivery. The baby was also examined with permission from the mother after hand washing with soap under running water and dried with towel. On examination, there was no abnormality detected. The cord was inspected for bleeding and discharge but there was none. The procedure for bathing the baby was explained to the mother. All items to be used for the procedure were assembled, these included : Plastic apron, soap and water, small towel, bath towel, basin, gloves, cot sheets, warm water, cotton wool swabs, chlohexidine jell , baby oil, powder, diaper , baby dress and sterile tray was set for cord dressing with an extra cord clamp. A plastic apron was put on. Hands were washed with soap and water and dried with clean towel.

Both cold water and hot water were mixed together and the temperature of the water was checked using the elbow. Gloves were worn and the baby was put on a protected flat surface and was undressed. Baby was then wrapped with a cot sheet with the head exposed for it to be bathed. The eyes were cleaned with clean cotton wool swabs soaked in clean water from inner canthus to outer canthus and the face cleaned with damp face towel and dried. The nape of the baby's neck was supported with one hand. The head was supported and the baby's ears plugged with two fingers. The head was then washed with soapy sponge. Baby was then lifted off flat surface, supporting the nape of the neck and the body resting in the elbow, to the edge of the basin and soap rinsed off baby's hair and dry. Baby was then put on protected flat surface and exposed. The arms and front of trunk were washed paying attention to the skin folds. The back of the baby was turned with one arm supporting the chest and with a hand holding the distal arm of the baby. The back was washed down to the feet, paying attention to the skin folds. Baby was supported firmly and immersed in warm water, with head above water and rinsed thoroughly. Baby was then placed on the flat surface covered by a bath towel. A small towel was used to dry the baby, paying attention to skin folds. Baby oil, as well as, powder was applied on the baby. The baby was wrapped with clean cot sheet after which the cord was exposed. The gloves were removed, hands were washed with soap and water and sterile gloves worn. The cord was inspected for bleeding but there was none. The whole cord was dressed with chlohexidine jelly from the base upwards and lastly tip of the cord. The cord was left exposed to air dry. Baby was dressed and diaper was put on. The baby was wrapped with clean dry cot sheet to maintain the temperature and given to the mother. The mother was thanked for the co-operation and was accompanied to the bedside. The working surface and the instruments were decontaminated with

0.5% chlorine solution for 10 minutes; it was then washed. The gloves were removed and hands washed and dried and the procedure was documented.

Mother was informed that the baby will be immunized against tuberculosis with Bacilli Calmatte Guerin (BCG) which will form a blister and scar later and that she should not apply anything on it.

4.3 FIRST DAY POST DELIVERY (DISCHARGE)

The first day of puerperium was on 30th December, 2020, client woke up around 7:00am, cleaned her teeth, took a warm bath and a quick head to toe examination was done with no abnormality been detected. On examination the breast was examined for lactation and it was true. The abdomen was also examined for tenderness, masses and pain but it was normal. The state of the uterus was contracted and the fundal height was 15cm. The lochia was reddish in colour (rubra) after which client was given warm water to bath. Then enquiries about the after pains were made and she said it has subsided. Client's assessment was recorded as follows:

Observations	**Morning**
Temperature	36.5˚C
Pulse	81bpm
Respiration	20cpm
Blood pressure	120/70mmHg
Lochia	Rubra
Fundal height	15cm
Condition of the uterus	Contracted
Breast	Lactating

Madam Alima was educated on postnatal exercise and was encourage to perform the kegel exercise to strengthen the perineal muscles. Madam Alima was served with weannig mix provided for mothers at labour ward unit and bread as breakfast. Her second dose of vitamin A 200,000 international unit orally was given. The baby was also examined with permission from the mother after hand washing with soap and water and dried with towel. On examination, there was no abnormality detected, baby suckles well and it skin was pink in colour. There was no bleeding from the cord and it was cleaned and fresh. Baby had pass urine and stool after which baby was bath with a warm water and the cord dressed with chlohexidine gel.

The baby's assessment was recorded as follows:

Observations	**Morning**
Temperature	36.5˚C
Apex beat	128bpm
Respiration	42cpm
Skin colour	Pink
Cord condition	Clean and fresh
Cord bleeding	No
Suckling	Yes
Weight	3.4kg
Stool Colour	Meconium

Then baby was dressed and wrapped loosed in a warm sheet and was given to the mother to breastfeed. All findings were communicated to the mother. Later in the morning, the baby was given immunizations, which were Bacille Calmette Guerin (BCG) 0.05ml vaccine intra- dermal

on the right upper arm and mother was advised not to apply anything to the site in order to ensure effectiveness of the vaccine and Polio "O" (OPVO) vaccine 2 drops at the back of the tongue. This immunization was given by a community health nurse and was aimed at protecting the baby from acquiring Tuberculosis and Poliomyelitis respectively. Client was told to come with the baby to take the rest of the immunization as schedule to protect the baby from any of the childhood preventable diseases like Measles, Tetanus, and Diphtheria etc.

Posture, positioning and fixing baby to breast were demonstrated to the client during which she was encouraged to sit with her back to a wall or flat surface and use a foot rest to support when breastfeeding. Client was asked to give a return demonstration and it was perfectly done. Client was informed about discharged that day. Madam Alima was educated on healthy adequate nutritious diet especially mashed kenkey and groundnut to help in the production of more breast milk and improve immunity as well, and could help repair worn out tissues. Client was also educated on personal hygiene and the various family planning methods available. The essence of the exercise was explained to her that it would help the pelvic organs to return to their original positions. Furthermore, client was educated on demand feeding and exclusive breast feeding.

Madam Alima was insured therefore the medicines were collected from the pharmacy with health insurance card and some money paid for other billings. Routine drugs were served as prescribed. Both mother and baby were reassessed by the Midwife In-Charge during which no abnormalities were detected. Client and baby's assessment were recorded as follows;

Mother

Observation	**Evening**
Temperature	36.5˚C
Pulse	79bpm
Respiration	21cpm
Blood pressure	120/80mmHg
Lochia	Rubra
Fundal height	15cm
Condition of the uterus	Contracted
Breast	Lactating

Baby

Observations	**Evening**
Temperature	36.6˚C
Apex beat	125bpm
Respiration	45cpm
Skin colour	Pink
Cord condition	Clean and dry
Cord bleeding	No
Suckling	Yes
Weight	3.4kg
Stool colour	Meconium

Client's drugs were given and the dosage and time for taking the drug were explained as follows:

1. Tablet Ferrous Sulphate 200 milligram daily for 7 days
2. Tablet Multivite200 milligram daily for 7 days
3. Tablet Folic Acid 5 milligrams daily for 7 days
4. Tablet Paracetamol 1g tid for 3 days.

Madam Alima was helped to pack their belongings and was educated on intended postnatal visits for a period of one week which was explained as a regular visit to the house for seven days for continuity of care. Client was educated on how to manage some common breast problem such as cracked nipple, breast engorgement, mastitis and was encouraged not to apply anything on the cord rather than gel provided. She was also encouraged to register the baby at the birth and death registry. Then emphasis was laid on the fact that first postnatal visit to the clinic would be 7th January, 2021 and was told visits will be paid to her at home before the date for the visit to the clinic to assess the condition of herself and the baby. When it was exactly 5:00pm she was discharged. Client was congratulated and bid farewell.

POST NATAL VISITS

4.4 FIRST POSTNATAL HOME VISIT

On 31st December, 2020, client was visited in the home at 8:00am and 4:00pm as scheduled. On arrival, greetings were exchanged, enquiry about their health and that of the family was made to which client responded they were all fine. Permission was asked to do the examination.

Client's assessments were recorded as follows

Observations	**Morning**	**Evening**
Temperature	36.7˚C	36.6 ˚C
Pulse	80bpm	78bpm
Respiration	20cpm	19cpm
Blood pressure	110/60mmHg	110/70mmHg
Lochia	Rubra	Rubra
Fundal height	14cm	14cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

Head to toe examination was done on the baby but there was no abnormality found.

The baby was assessed and recorded as follows;

Observations	**Morning**	**Evening**
Temperature	36.4˚C	36.6 ˚C
Apex beat	128bpm	126bpm
Respiration	40cpm	41cpm
Skin colour	Pink	Pink
Cord condition	Clean but fresh	Clean but fresh
Cord bleeding	No	No
Suckling	Yes	Yes
Weight	3.3kg	3.3kg
Stool colour	Meconium	Meconium

The baby was top and tailed and the cord was dressed nicely with chlohexidine gel making the cord look clean. After that the baby was dressed up, wrapped in a warm sheet and was given to the mother to breastfeed. According to Madam Alima, the baby passed meconium and urine. Client was encouraged to practice demand feeding and exclusive breastfeeding. Client was also encouraged to maintain personal and environmental hygiene to prevent infections. After interacting with client for some time, permission was sought to leave and it was granted.

4.5 SECOND POSTNATAL HOME VISIT

On 1st January, 2021 at 8:00am and 4.20pm, Madam Alima and her family were visited for the second day. The main aim of the visit was to assess their general condition and progress of their health. A warm welcome was received on arrival, it was a New Year, a special celebration for Christians but Madam Alima and her families were happily celebrating the New Year and thanking Allah for His blessings and protection upon the lives of everyone in the family. We ate and enjoyed the special day together. The purpose of the visit began after some hours, Madam Alima was examined, breast was lactating well and the uterus was well contracted, symphysio-fundal height was 13 centimeters. Perineal pad was inspected and lochia was bright red in colour (rubra), the flow was moderate and not offensive. Client was encouraged to fix the baby properly to the breast when feeding. Client was congratulated after the examination. She was asked if there were any complains which she complained of not being able to empty her bowel and was encouraged to take in more fruits and roughages as well.

Client's assessment was recorded as follows;

Observations	**Morning**	**Evening**
Temperature	36.5˚C	36.4˚C
Pulse	78bpm	76bpm
Respiration	20cpm	22cpm
Blood pressure	120/60mmHg	120/70mmHg
Lochia	Rubra	Rubra
Fundal height	13cm	13cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating

The baby was topped and tailed while singing a lullaby and cord dressed for the second time and it looked fresh but clean. Baby passed greenish brown stool and urinated during the process.

The baby was assessed and recorded as follows;

Observations	**Morning**	**Evening**
Temperature	36.7˚C	36.6˚C
Apex beat	132bpm	134bpm
Respiration	40cpm	42cpm
Skin colour	Pink	Pink
Cord condition	Clean and drying	Clean and drying
Cord bleeding	No	No
Suckling	Yes	Yes
Weight	3.3kg	3.3kg
Stool colour	Greenish	Greenish

The baby was then dressed nicely and wrapped loosely in a warm sheet and made comfortable in bed. Client complained that her baby cries excessively and was encouraged to change baby's diaper when it soils and should lets observe. Permission was then sought to leave and it was granted.

4.6 THIRD POSTNATAL HOME VISIT

On 2nd January, 2021 at 8:05am and 4:10pm, visits were paid to Madam Alima and the family, they were all in good health. Enquiry about the constipation was made and she said it has subsided. Client was examined from head to toe. The breast was lactating well but slightly engorged and was encouraged to attach baby well to breast.

Client's assessment was recorded as follows;

Observations	**Morning**	**Evening**
Temperature	36.6˚C	36.3˚C
Pulse	82bpm	80bpm
Respiration	20cpm	21cpm
Blood pressure	110/70mmHg	110/60mmHg
Lochia	Serosa	Serosa
Fundal height	12cm	12cm
Condition of the uterus	Contracted	Contracted
Breast	Lactating	Lactating but slightly engorged

Madam Alima's sister in-law was assisted to topped and tail the baby and was also taught how to use chlohexidine gel in dressing the cord. The sister in-law wrapped the baby loosely in a sheet and made comfortable in bed.

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

Observations	**Morning**	**Evening**
Temperature	36.6˚C	36.7˚C
Apex beat	133bpm	132bpm
Respiration	44cpm	40cpm
Skin colour	Pink	Pink
Cord	Shrinking	Shrinking
Cord bleeding	No	No
Suckling	Yes	Yes
Weight	3.4kg	3.4kg
Stool colour	Yellowish	Yellowish

4.7 FOURTH POSTNATAL HOME VISIT

On the 3rd January, 2021 approximately 8:00 am, client was visited once again. On arrival, Madam Alima was brushing her teeth. The rest of the family members were asked how they were doing and they responded they were fine by God's grace. Hot water was already available for bathing of which client requested to perform some exercises before bathing, before then assessment was made, aside everything being normal, her breast was engorged and was encouraged to express milk to make the breast comfortable until the engorgement stops and also to apply warm compresses to the breast to relieve congestion.

Client's findings were recorded as follows;

Observations	**Morning**
Temperature	36.5˚C
Pulse	80bpm
Respiration	22cpm
Blood pressure	110/70mmHg
Lochia	Serosa
Fundal height	11cm
Condition of the uterus	Contracted
Breast	Lactating but engorged

Baby was topped and tailed by the client under supervision. Baby's cord was dressed with chlohexidine gel and it looked dried and about to slough off, and baby was dressed nicely and wrapped in white cloth and made comfortable in bed.

Baby was assessed and the observations were recorded as follows;

Observations	**Morning**
Temperature	36.7˚C
Apex beat	130bpm
Respiration	42cpm
Skin colour	Pink
Cord	Dried and almost off
Cord bleeding	No
Suckling	Yes
Weight	3.5kg
Stool colour	Yellowish brown

Client was encouraged to frequently breastfeeding the baby and also ensure a conducive environment to help baby to sleep and rest well as the siblings could disturb since school was closed down due to the COVID-19 pandemic disease. Client was again encouraged to sleep and rest during the day when her family members are around to help cater for the baby and in performing the household duties. Madam Alima was informed of the next home visit and permission was asked to leave and it was granted.

4.8 FIFTH POST NATAL HOME VISIT

On 4th January, 2021, Madam Alima and family were visited at 8:20am. The aim of the visits was to know how they were faring. On arrival and seeing all the family members, they were all in good health and their environment was clean. Enquiry was made about the breast engorgement and client complained less and was encouraged to continue applying warm compress and also allow baby to empty one breast completely before offering the other. Client again complained of not being able to sleep well during the night due to baby feeding in the night. Reassurance was given to client to take a nap anytime baby sleeps and whenever possible. Head to toe examination was done and there was no abnormality detected on the client, perineal pad was inspected for lochia and the flow was moderate, pink in colour (serosa) and not offensive. Findings recorded as follows;

MOTHER

Observations	**Morning**
Temperature	36.5˚C
Pulse	76bpm
Respiration	20cpm
Blood pressure	120/60mmHg
Lochia	Serosa
Fundal height	10cm
Condition of the uterus	Contracted
Breast	Lactating

The baby's cord was off and was bathed and navel dressed with chlohexidine. Yellowish-brown stool and urine were passed during bathing. Baby was wrapped loosely in a warm baby sheet. Baby's assessment was recorded as follows;

Observations	**Morning**
Temperature	36.5˚C
Apex beat	142bpm
Respiration	41cpm
Skin colour	Pink
Cord	Off
Cord bleeding	No
Suckling	Yes
Weight	3.6kg
Stool colour	Yellowish brown

Client was then asked whether the baby is able to hold the breast and suckle well and client said not very well so it was demonstrated for observation once again and a return demonstration was done. The whole family was told not to apply chalk or hot water at the umbilical area of the baby in order not to cause infections and the fontanelles should be left till closure on its own as this will permit complete maturation of the brain mater. Permission was asked to leave and it was granted.

4.9 SIXTH POSTNATAL HOME VISIT

On the 5th January, 2021, at 8:00am, Client was visited again. On arrival, Madam Alima was met with sister in-law and husband, they were asked how they were doing and responded they were all fine by grace. Enquiries about the breast engorgement and inadequate sleep were made and she said both have subsided.

Client's assessment was done and recorded as follows;

Observations	**Morning**
Temperature	36.6˚C
Pulse	84bpm
Respiration	21cpm
Blood pressure	120/70mmHg
Lochia	Serosa
Fundal height	9cm
Condition of the uterus	Contracted
Breast	Lactating

The baby was bathed by the mother under supervision because the cord had fallen earlier after head to toe examination was done where no abnormalities were detected. Baby was dressed and breastfed. Baby's assessment was recorded as follows;

Observations	**Morning**
Temperature	36.7˚C
Apex beat	132bpm
Respiration	40cpm
Skin colour	Pink
Cord	Healing
Cord bleeding	No
Suckling	Yes
Weight	3.7kg
Stool Colour	Yellowish brown

Client reported of backache when breastfeeding the baby and was encouraged to use pillows to support her back or lie when breastfeeding the baby to relieve pain. They were informed about the next day's visit to be the last postnatal visit to them. They were not really happy about the last visit announcement, but they were assured of meeting again at the postnatal clinic. They were bid goodbye after everything.

4.10 SEVENTH POST NATAL HOME VISIT

The last post natal home visit was on the 6th January, 2021 at 8:00am. On arrival, client's baby was with her while singing a lullaby together with the other siblings who because of the COVID-19 lock down, did not go to school and the husband looked very happy. Greetings were then

exchanged. Enquiry about the backache was made and she said it has subsided and routine examinations started. On examination, there was no abnormality detected and breast engorgement has resolved. Client's assessment was recorded as follows:

Observations	**Morning**
Temperature	36.4˚C
Pulse	80bpm
Respiration	23cpm
Blood pressure	120/80mmHg
Lochia	Serosa
Fundal height	8cm
Condition of the uterus	Contracted
Breast	Lactating

The baby's assessment was done and there was no abnormality detected on the baby. After that, it was bathed by the sister-in law in my presence for the last time.

Baby's vital signs as well as other assessment was recorded as follows;

Observations	**Morning**
Temperature	36.6˚C
Apex beat	140bpm
Respiration	44cpm
Skin colour	Pink
Cord	Off
Cord bleeding	No
Suckling	Yes
Weight	3.8kg
Stool colour	Yellow

Client was encouraged to report to the clinic for postnatal examination of herself and the baby. The importance of coming for postnatal was explained to client and the date was made known. They were then discharged from home visits. The family was thanked for their understanding and cooperation. They also expressed their gratitude.

4.11 FIRST POST-NATAL VISIT TO THE CLINIC

Madam Alima and her baby together with her sister in-law reported to the postnatal clinic on 7th January, 2021 at 9:00am. The aim of the visit was to check on the improvement on the condition of the mother and baby and to circumcise the baby too. Client was welcomed and offered a seat. Baby's weight was 3.9kg, temperature was 36.4 degrees Celsius apex beat 132bpm and respiration 42cpm. The procedure that was to be performed on Madam Alima was explained to her to consent, which she did. Specimen bottle was given to take specimen of her midstream urine in order to test for sugar and albumin but the results of the test was negative. After client

has been asked to empty her bladder, she was helped onto the examination bed and head to toe examination started, on the head, hair was neatly kept, with the eyes, there was no discharges and was not pale or jaundiced. The breasts were examined and was well lactating with no abnormalities detected. Client was educated on proper positioning and attachment of the baby to the breast. There was no abnormality detected in the mouth and nodules absent on the neck.

On abdominal palpation, there was no scar, tenderness nor enlarged liver or spleen. The perineum was intact with no abnormal vaginal discharge. The perineal pad was also examined and the lochia was pinkish in colour.

Head to toe examination was also performed on the baby but no abnormality was detected except for few heat rashes on the baby's skin. Client was reassured that its normal for babies to develop skin rashes as their skin is sensitive to a different temperatures and advised to dress the baby according to the weather, should ensure baby wears clean and dry clothing, wash her hands before and after handling the baby and ensure diapers are changed frequently. The umbilical stump was inspected and it was healed. Client was encouraged to ask questions but she said there was none. Mother was educated on exclusive breastfeeding, importance of attending child welfare clinic and to continue practicing the pelvic floor muscle exercise. Client was congratulated for taking good care of the child and herself. She was reminded of the six weeks post natal visit on 18th February, 2021. Findings were communicated to her and recorded as follows;

MOTHER

OBSERVATION	**READING**
Temperature	36.5^{o}C
Pulse	76 bpm
Respiration	21cpm
Blood pressure	110/70mmHg
Haemoglobin level	13.0g/dl
Symphysio-fundal height	7cm

BABY

OBSERVATION	**READING**
Temperature	36.4^{0}C
Apex heart beat	132bpm
Respiration	42cpm
Skin colour	Pink
Cord bleeding	No
Weight	3.9kg
Sucking	Yes

Stool colour	Yellow

Madam Alima was informed that the circumcision is about to be done and was asked if she would like to observe but replied in the negative. The baby was prepared and circumcised by the midwife in-charge. The circumcised area was wrapped with gauze after which baby was clothed and given to mother to breastfeed. Education was then given to wash hand with soap and water before handling baby and to always keep the wound dry to prevent infection and report any signs of bleeding, swelling or discharge.

TERMINATION OF CARE

Explanation was given to Madam Alima on the need to be handed over to the midwife in-charge for continuity of care on 7th January, 2021. Explanation was made to her that our programme was ending that day but client was reassured of midwife in charge's support. She was also encouraged to register her child at the birth and death registry and educated on family planning. Client was accompanied to her house and a seat was offered. Client and her family was thanked for their cooperation, information provided and permission was sought to leave.

4.12 SECOND POSTNATAL VISIT TO THE CLINIC

According to the midwife in-charge, Madam Alima reported on 18th February, 2021 for the sixth week postnatal care. There was no abnormality detected on examination. Client and the baby were fine. Mother's vital signs recorded as follows:

Temperature	36.5^{o}C
Pulse	80bpm
Respiration	20cpm
Blood pressure	110/60bpm

Head to toe examination was performed on baby with no abnormalities found. The baby was given the due vaccination that was oral polio 1, Penta 1(diphtheria, hepatitis B, tetanus, pertusis and haemophilus influenza B), 0.5mls intra muscularly at left lateral thigh, pneumococcal vaccine 0.5mls at right lateral thigh (protection against pneumonia) and rotavirus 1.5mls orally was given (protection against diarrhoea). Madam Alima was informed of the side effect and encouraged to report to the facility any time she encountered any health related problems.

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

Temperature	36.6^{o}C
Apex beat	135bpm
Respiration	40cpm
Weight	4.5kg

Madam Alima was encouraged to ask questions but she asked none and made no complaints either. She was reminded on exclusive breastfeeding, rest and sleep, exercise and nutrition. According to midwife in charge, client was finally handed over to the Public Health nurse in Nkrankwanta Health Centre for continuity of care but she was asked to report to the facility any time she encountered any health related problem.

4.13 NURSING CARE PLAN

PROBLEMS IDENTIFIED DURING PUERPERIUM

On the 29th December, 2020, client complained of:

1. After Pain.

On the 1st January, 2021, client complained of:

2. Constipation

On the 3rd January, 2021, client complained of:

3. Engorged breast

On the 4th January, 2021, client complained of:

4. Inadequate sleep

On the 5th January, 2021, client complained of:

5. Backache

SHORT TERM OBJECTIVES

1. Client's after pains will reduce within 5 hours.

2. Client will empty her bowel within 24 hours.

3. Client's breast engorgement will resolve within 48 hours

4. Client will sleep an hour during the day and 6 hours during the night.

5. Client's backache will resolve with 24 hours

LONG TERM OBJECTIVES

Client and baby will go through puerperium successfully without any complication

NURSING CARE PLAN FOR MADAM ALIMA DURING PUERPERIUM

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTION	DATE/ TIME	EVALUATION	SIGN
29/12/20 @ 8:00am	After pain related to contractions of the uterus after delivery.	Madam Alima's after pain will reduced within 5 hours as evidenced by; 1. Client verbalizing that the pain has reduced. 2. Midwife observing that client have a cheerful facial expression.	1. Reassure client that the condition can be managed. 2. Explain the physiology of after pain to client. 3. Encourage client to put warm compress on the lower abdomen. 4. Encourage client to empty her bladder when she has the urge. 5. Encourage client to feed baby on demand.	1. Client is assured that the after pain would be reduced. 2. The physiology of the after pain was explained to client that it was as a result of the production of oxytocin during breastfeeding that initiate contractions and causes the pains. 3. Client was applied warm compress on the lower abdomen. 4. Client was emptying her bladder when she has the urge. 5. Client fed baby on demand.	29/12/20 @ 1:00pm	Goal fully met as; 1. Client verbalized that the pain has reduced. 2. Midwife observed client with a cheerful facial expression	A.G

NURSING CARE PLAN FOR MADAM ALIMA DURING PUERPERIUM.

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES AND OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
01/01/21 @ 8:00am	Constipation related to decrease gastrointestinal motility resulting from confinement during puerperium.	Client will empty her bowel within 24 hours as evidenced by 1. Client verbalizing that she is able to move her bowel without straining. 2.Husband verbalizing to midwife that client has visit the toilet	1. Reassure client that she will move her bowel freely 2. Encourage client to eat food containing fibres eg. Nkontomire 3. Encourage client to perform postnatal exercise. 4. Encourage client to take at 3000mls of fluids every day. 5.Encourage client to attend nature's call whenever she has the urge	1. Client was reassured that she would be able to move her bowel freely. 2. Client was eating vegatables fruits and highly fibre diet. 3. Client walked some few distances each morning and evening and also do abdominal exercises 4. Client took 3000mls of fluids every day. 5. Client attended nature's call whenever she has the urge.	02/01/21 @ 8:00am	Goal fully met as; 1. Client verbalized that she now moves her bowel without straining. 2. Husband verbalized to midwife that client has visited the toilet.	A.G

NURSING CARE PLAN FOR MADAM ALIMA DURING PUERPERIUM CONTINUES

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
03/01/21 @ 8:00am	Breast engorgement related to poor attachment of baby to breast	Client's breast engorgement will subside within 48 hours as evidenced by 1. Client verbalizing that tenderness and heaviness of the breast has relieved. 2. Midwife visualizing that client is breastfeeding baby comfortably.	1. Reassure client that breastfeeding baby on demand helps in subsiding the engorgement. 2.Encourage client to support the breast with a well- fitting brassiere 3. Teach client on positioning and fixing baby to breast when breastfeeding. 4. Encourage client to apply warm compress to the breast to relieve congestion.	1. Client was reassured breastfeeding baby on demand help subside the engorgement. 2. Client supported the breast with a well- fitting brassiere. 3. Positioning of baby to breast was taught and demonstrated. 4. Client applied warm compress to breast to relieve congestion.	05/01/21 @ 8:00am	Goal was fully met as; 1. Client verbalized that the tenderness and heaviness of her breast has subsided. 2. Midwife observing that client's breast engorgement has subsided	A.G

NURSING CARE PLAN FOR MADAM ALIMA DURING PUERPERIUM.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
04/01/21 @ 8:20am	Inadequate sleep related to night feeding.	Client will be able to sleep for at least an hour during the day and 6 hours during the night as evidenced by; 1. Client verbalizing that she is able to sleep for an hour during the day and 6 hours at night 2. Husband observing that client was sleeping.	1. Reassure client that she will be able to sleep well. 2. Encourage client to feed baby well before sleeping. 3. Educate client to sleep in day time while baby is asleep. 4. Encourage mother to have warm bath before sleep. 5. Encourage relatives to take care of baby if not crying to allow mother to sleep.	1. Client was reassured that she would sleep well. 2. Baby was fed fully and winded before sleeping. 3. Client slept in day time while baby is asleep. 4. Client took a warm bath before she went to bed. 5. Relatives took care of baby when not crying.	05/01/21 @ 8:20am	Goal fully met as; 1. Client verbalized that she now sleeps an hour in the day and 6 hours at night. 2. Husband observes that client sleeps well.	A.G

NURSING CARE PLAN FOR MADAM ALIMA DURING PUERPERIUM.

DATE/ TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE/ TIME	EVALUATION	SIGN
05/01/21 @ 8:00am	Backache relate to poor posture during breastfeeding.	Client's backache will resolve within 24 hours as evidenced by 1. Client verbalizing that backache has resolved. 2. Midwife observing client wear a cheerful facial expression.	1. Reassure client of reduction in pain. 2. Educate client to support her back when breastfeeding and to sit with her back straight. 3. Teach client on correct positioning and attachment of baby to breast. 4. Educate client to lean against the wall during breastfeeding. 5. Serve prescribed analgesics (paracetamol) to relieve pain.	1. Client was reassured that her pain will be reduced. 2. Pillows were used to support her back and education was given to her on how to sit during breastfeeding. 3. Client positioned baby's head in her brachial region and baby's abdomen touched hers while baby's body was straight and more areola directed into the mouth. 4. Client leaned against a flat surface when breastfeeding baby to prevent backache. 5. Tablet paracetamol 1g tid x 3 was given to relive pain	06/01/21 @ 8:00am	Goal was fully met as 1. Client verbalized that her backache has resolved. 2. Midwife observed client with a cheerful facial expression.	A.G

SUMMARY AND CONCLUSION

The Client/Family Centered Maternity Care Study was conducted on Madam Alima Yakubu a 31year-old gravida3 para2 and her entire family through pregnancy, labour and puerperium and she went through these processes safely without any complications.

Madam Alima became a regular attendant to the clinic since 3rd June, 2020. She was managed through pregnancy, labour and puerperium safely through which all minor disorders were taken care of using the nursing care plan and goals were met when evaluated. She had a spontaneous vaginal delivery to a life male baby on 29th December, 2020 and discharged the next day. Client and family were visited for the first seven days after delivery.

She visited the clinic on her first week and six weeks postnatal. Madam Alima was given a focused and comprehensive care throughout her pregnancy, labour and puerperium. Madam Alima and her baby were in a healthy condition and they were handed over to the Midwife-In-Charge for continuity of care. Client and her family were much grateful at the end of the study.

Client and Family Centered maternity care is an effective approach to expectant mothers and their families. It is very interesting but need a lot of hard work, commitment, encouragement, supervision and advices before one can achieve her aim.

The approach of nursing Madam Alima and her family has paved way for me to care for a pregnant woman and be able to find solutions to problems which are encountered during pregnancy, labour and puerperium. It has also broadened my knowledge on issues concerning pregnancy, labour and puerperium. With this experience gained, the best standard of care will be

rendered to all clients that will come my way irrespective of their status and the environment in order to reduce maternal and infant morbidity and mortality.

The care study is an important and managerial tool which gives opportunity to student midwives to put into practice theoretical knowledge gained in the classroom and to be able to deal with obstetric problems as midwifery professional.

BIBLIOGRAPHY

Fraser, D.M. and Cooper A. M. (2009).*Myles Textbook for Midwives* (15th edition).London: Churchhill Livingstone Elsevier Ltd.

Ghana heath service (2008), *National Safe Motherhood Service Protocol. Accra*: Yamens Press Limited.

Henderson, C. and Macdonald, S. (2009).*Mayers' Midwifery* (13th edition), London: Bailliere Tindal, Elsevier Limited.

King, L .T. et al (2014), *Varney's Midwifery* (5th edition), New Delhi: Jones and Bartlett India Pvt. Ltd.

Konar, H. (2013), D.C.Dutta's *Textbook of Obstetrics*. Kolkata: New Central Book Agency (P) Ltd.

Marshall, J. and Raynor, M. (2014).*Myles Textbook for Midwives* (16th edition) London: Churchhill Livingstone Elsevier Limited.

Ministry of health and Ghana Health service, *Maternal Health and Record Book* registration number 409/2020 Dormaa West District Hospital-Nkrankwanta.

Tiran,D. (2008), *Bailliere's Midwives Dictionary* (11th edition), London: BaillereTindall Elsevier Ltd.

APPENDIX 1

(ANTENATAL RECORDS OF MADAM ALIMA)

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN /SUGAR	GESTAT-IONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE(FH)	TREATMENT GIVEN	COMPLAINS	SIGN
03/06/20	65kg	110/70mmHg	Negative/ Negative	10weeks	_	_	_	_	Routine drugs , Tab Paracetamol 1g	Headache, bitterness in the mouth and General body weakness	R.B
01/07/20	65kg	105/64mmHg	Negative/ Negative	14weeks	_	_	_	_	Routine drugs	No complains	L.A
29/07/20	66kg	100/60mmHg	Negative/ Negative	18weeks	17cm	_	_	Present	Routine drugs	No complains	L.A
26/08/20	67kg	120/74mmHg	Negative/ Negative	22weeks	21cm	_	_	Present	Routine drugs	Feels well	R.B
23/09/20	67kg	118/73mmHg	Negative/ Negative	26weeks	25cm	_	_	150bpm	Routine drugs	No complains	R.B
21/10/20	68kg	109/61mmHg	Negative/ Negative	30weeks	29cm	_	_	148bpm	Routine drugs	Well	R.B

ANTENATAL RECORDS OF MADAM ALIMA CONTINUES

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATION-AL AGE IN WEEKS	FUNDAL HEIGHT(CM)	PRESENTATION	DESCENT OF FETAL HEAD	FETAL HEART RATE(FH)	TREATMENT GIVEN	COMPLAINS	SIGN
04/11/20	68kg	110/70mmHg	Negative/ Negative	32weeks	31cm	_	_	137bpm	Routine drugs	No complains	L.A
18/11/20	69kg	112/60mmHg	Negative/ Negative	34weeks	33cm	Cephalic	_	141bpm	Routine drugs	No complains	L.A
02/12/20	70kg	120/77mmHg	Negative/ Negative	36weeks	35cm	Cephalic	5/5th	144bpm	Routine drugs, Vitamin B	Loss of appetite	L.A A.G
09/12/20	71kg	110/66mmHg	Negative/ Negative	37weeks	36cm	Cephalic	5/5th	143bpm	Routine drugs	Healthy	L.A A.G
16/12/20	72kg	108/60mmHg	Negative/ Negative	38weeks	37cm	Cephalic	5/5th	138bpm	Routine drugs	Well	L.A A.G
23/12/20	74kg	120/81mmHg	Negative/ Negative	39weeks	38cm	Cephalic	5/5th	145bpm	Routine drugs	No complains	L.A A.G

ITN Given – 03/06/20

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1 Yes TD 2 and TD 3 NO TD 4		TD 5 NO	
	CURRENT TD 4th dose		Date		Date	
			03/06/20			
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 29/07/2020	Gestation age In weeks 18weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 26/08/2020	Gestation age In weeks 22weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)23/09/20	Gestational age in weeks 26weeks
	4th dose 3 tabs (Direct observed therapy)21/10/20	Gestation age in weeks 30weeks	5th dose 3 tabs (Direct Observed Therapy) 04/11/20	Gestation age in weeks 32 weeks		

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

APPENDIX II

(COMPLETE DIAGNOSTIC INVESTIGATION ON MADAM ALIMA)

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
03/06/2020	Urine	Protein	Negative	Negative	Normal
		Glucose	Negative	Negative	
		Haemoglobin level	11-16gms/dl	12.5 g/dl	Normal
		PMTCT	Negative	Negative	
		Syphilis	Negative	Negative	
		Rhesus factor	Negative/Positive	Positive	
		Grouping	A, B, AB, O	O+	
		Sickling Test	Negative	Negative	
01/07/2020	Urine	Glucose	Negative	Negative	Normal
		Protein	Negative	Negative	

COMPLETE DIAGNOSTIC INVESTIGATION CONTINUES

DATE	SPECIMEN	INVESTIGATION	NORMAL RANGE	FINDINGS	REMARKS
29/07/2020	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal
26/08/2020	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal
23/09/2020	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal
21/10/2020	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal
04/11/2020	Urine Blood	Protein Glucose Haemoglobin level	Negative Negative 11-16gms/dl	Negative Negative 12.8gms/dl	Normal Normal
18/11/2020	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
02/12/2020	Urine Blood	Protein Glucose Haemoglobin level	Negative Negative 11-16gms/dl	Negative Negative 13.2gms/dl	Normal Normal
09/12/2020	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal
16/12/2020	Urine Blood	Protein Glucose Haemoglobin level	Negative Negative 11-16gms/dl	Negative Negative 13.4gms/dl	Normal Normal
23/12/2020	Urine	Protein Glucose	Negative Negative	Negative Negative	Normal Normal

APPENDIX III

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Caps iron (III) Polymaltose Complex	Haematinics	100 milligrams once daily	Orally	Aids in red blood cell formation	Increased haemoglobin level	Dark stools, diarrhoea and constipation	None observed
Folic acid	Vitamin preparation	5 milligram once daily	Orally	Proper formation and function of red blood cell	Haemoglobin level increased	Nausea and vomiting	None observed
Tetanus injection	Vaccine	0.5 milligram stat (3^{rd} dose)	Subcutaneously	Protection against tetanus	Tetanus was prevented	Fever and urticarial rash	None observed
Tablet Sulphadoxine Pyrimethamine	Anti-malaria and prophylaxis	3 tablets given at 16 weeks/quickening's repeated at 4week interval till delivery.	Orally	Prevention of malaria	Prevention of malaria in pregnancy	Nausea, itching, headache, Dizziness	None observed

PHARMACOLOGY OF DRUGS FOR THE MOTHER

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION AND USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Tablet paracetamol	Analgesics	1 gram three times daily for three	Orally	Helps to relieve pain	Pain was relieved	Prolong use causes damage to the liver	None observed
Capsule vitamin A	Group A vitamin supplement	200,000 units	Orally	Growth development and proper sight	Normal vision and healthy skin	Vomiting	None observed
Injection Pitocin	Oxytocic drug	10 units	Intramuscularly	Stimulate uterine contractions	Good uterine contraction and control of bleeding	Nausea and vomiting	None observed
Tablet multivitamin	Vitamin preparation	200 milligrams daily	Orally	Increases appetite. Help in the formation of red blood cell	Increases appetite	Gastrointestinal disturbance	Constipation

APPENDIX IV

PHAMARCOLOGY OF DRUGS FOR THE BABY

NAME OF DRUG	CLASSIFI-CATION	DOSAGE	ROUTE	ACTION/ USES	ACTUAL EFFECT	SIDE EFFECT	SIDE EFFECT EXPERIENCED
Vitamin K	Coagulant	1milligram	Intramuscular	Production of prothrombin	No bleeding	None	None observed
Gentamycin eye drop	Prophylaxis antibiotic	2-3 drops	Instillation	Prevents eye infection	Infection was prevented	Nephroxicity	None observed
Polio vaccine	Antigen	2 drops	Orally	Production of antibodies against poliomyelitis	Diarrhoea and fever may occur.	None	None observed
Injection Bacillus Calmette Guerin (BGC)	Antigen	0.05 Milligram	Intradermal	Vaccinates neonates against tuberculosis	Tuberculosis prevention	Blister formation	None observed
Pnuemococcal	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against pneumonia	Pneumonia prevention	Redness at the side of injection and fever	None observed
5 in 1 vaccine (Pentavalent)	Antigen	0.5 milligram	Intramuscularly	Vaccinates neonates against diphtheria, pertusis (whooping` cough), tetanus, hepatitis B, heamophilus influenza type B	Prevention of childhood preventable diseases	Low grade fever	None observed
Rotavirus	Antigen	1.5 millligrams (2 drops)	Orally	Prevention of gastroenteritis	Gastroenteritis prevention	None	None observed

LABOUR CHART (PARTOGRAPH)

NEWBORN EXAMINATION CHART

POSTNATAL CHARTS (MOTHER AND BABY)

SIGNATORIES

THE STUDENT MIDWIFE

NAME: AGNES YEBOAH GYAN

SIGNATURE: ……

DATE: ……

THE SUPERVISOR THE MIDWIFE-INCHARGE (DORMAA WEST DISTRICT

HOSPITAL-- NKRANKWANTA)

NAME: MRS. JOYCE NAAZIE

SIGNATURE: ……

DATE: …….

THE SUPERVISOR

NAME: MS. ERNESTINA MENSAH

SIGNATURE: ……

DATE: …….

THE PRINCIPAL

NAME: MS. MONICA NKRUMAH

SIGNATURE: ……

DATE: ……