HOLY FAMILY NURSING AND MIDWIFERY TRAINING COLLEGE

BEREKUM

A CLIENT/FAMILY CENTERED MATERNITY CARE STUDY ON

MADAM BAAH PATRICIA

BY

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PREFACE

A family centered maternity care is the care and supervision given to the expectant mother and family throughout pregnancy, labour and puerperium.

It is based on a thoughtful understanding of the woman as a unique individual with peculiar needs which must be met within the context of the client's family. The care is extended to the members of the client's family as well as the community in which she lives.

Family centered maternity care gives each family member the education and support the family needs to welcome the new baby.

It helps to utilize all the skills and knowledge acquired from the various subjects taught in school to give care to meet the peculiar needs of the pregnant woman and her family.

The care study also serve as a partial fulfillment of an academic requirement of the Nursing and Midwifery Council of Ghana to license a student midwife to practice upon completion other course.

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INTRODUCTION

A family centered maternity care study is a tool that enables the student midwife to put into practice the knowledge and skills acquired in the course of her study or training.

The purpose and aim of this study is to help motivate learning positively. The study gives accurate information to the student midwife on professional standard care of client. This care given is based on identification of individual problems, analyzing them and some possible solutions provided.

This family centered maternity care study was carried out on Madam Baah Patricia a thirty-eight years old woman, gravid 3 Para 2 alive during the period of pregnancy, labour and puerperium.

The interaction with her started on 26th November 2020, during her 7thvisit to Jinijini health center as she was 36 weeks pregnant at that time. Interaction started when she came to the vital signs table. There are four chapters outline in this script.

Chapter one talks about client's particulars such as social, family, medical, surgical, menstrual lifestyle, past and present obstetrical history whiles chapter two talks about the antenatal care the client received and home visits made to client and chapter three talks about labour and its management. Finally, chapter four is about puerperium which involves an elaborate care gives to Madam Baah, the baby and the family after delivery. At the end of each chapter, is a care plan table outlined withthe problems identified, nursing orders and intervention.

Finally, summary, conclusion and bibliography as well as the various appendices like antenatal records, pharmacology of drugs, complete diagnosis investigations, maternity chart, newborn chart and partograph are all included.

LITERATURE REVIEW

PREGNANCY

Tiran (2008) defined pregnancy as the condition of having a developing embryo or foetus within the body; the state from conception to delivery of the fetus. The normal duration is 280 days (40 weeks or 9 months and 7 days) counted from the first day of the last normal menstrual period.

Darwin and Sian (2005) also said, pregnancy is the state of having a developing embryo or fetus within the body.

Ojo and Briggs (2006) also stated that, when pregnancy occurs menstruation ceases and returns some weeks or months after delivery. The hormones, progesterone and oestrogen, are produced in large quantity. These hormones exert some action on the various systems of the patient. The most outstanding of these changes is the growth which occurs in the uterus. The endometrium is converted into decidua and the uterus itself grows to accommodate the growing embryo. The uterus will have increased so much in size that at the end of pregnancy, it measures approximately 30cm by 22.5cm by 20 cm and weighs 1kilogramme. During pregnancy, the uterus becomes and abdominal organ.

Fraser and Copper (2009) also stated that, every pregnancy is a unique experienced for that woman and each pregnancy that the woman experiences will be uniquely different. This is why it is so important that, the midwife has a knowledge and understanding of the common disorders of pregnancy which include; constipation, leg cramp, backache, among others in order to advice the woman on strategies that will help her cope with the condition and minimize the effects she experiences.

Oduro-Kwarteng (2012) again said that, the growth and development of the fetus is affected by many aspects of the mother`s health; poor nutritional status, uses of drugs, alcohol and

cigarettes, use of unprescribed or some medications, herbal remedies, medical conditions, age at time of pregnancy and prenatal care.

ANTENATAL CARE

According to Marshall and Raynor (2014), Antenatal care refers to the care that is given to the pregnant woman from the time that conception is confirmed until the beginning of labour and also the midwife facilitates woman-centered care by providing her with accessible and relevant information to help her make an informed choices throughout pregnancy.

This book went on further to say that the aim of antenatal care is to monitor the progress of pregnancy to optimize maternal and fetal health. To achieve this, the midwife critically evaluates the physical, psychological and sociological effects of pregnancy on the woman and her family. The key principles of antenatal care by the midwife:

1. Providing a holistic approach to the woman' care that meets her individual needs.
2. Recognizing complications of pregnancy and appropriately referring women to the obstetric team or relevant health professionals or other organizations.
3. Facilitating the woman and her family in preparing to meet the demands of birth, and making a birth plan.
4. Offering parenthood education within a planned programme or on an individual basis.

Also according to Ghana Health Service (GHS) 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:

- 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.

- To detect and treat high-risk conditions arising during pregnancy, whether medical, surgical or obstetric.
- To ensure the delivery of a full term healthy baby with minimal stress or injury to mother and baby.
- To ensure safe delivery and postpartum health
- To help prepare the mother to breastfeed successfully, experience normal puerperium and take good care of the child physically, psychologically and socially.
- 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 toGHS (2008), the number of times a client needs to be seen during pregnancy may vary. For the uncomplicated pregnancy it is recommended that at least four ANC visits should be made according to the following schedule.

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

The third stage of labour; entails complete expulsion of the placenta and membranes, usually within 5-15 minutes of birth of the infant. The other feature of the third stage, apart from the detachment and expulsion and control of bleeding.

Also according to the GHS (2008), the goal of care during labour and delivery is to ensure the most positive outcome; a healthy mother and a healthy baby.

The specific objectives are;

- Proper management of the four stages of labour,
- Early identification and proper management (treatment and/or referral complications).

In view of the above, it can be deduced that, pregnancy involves care given to the pregnant woman during antenatal which includes educating the woman on the importance of antenatal visits, good nutrition, personal hygiene and management of minor disorders and preparations toward labour or delivery.

LABOUR

The World Health Organization (WHO) defined normal labour as one that is low throughout, spontaneous in onset with the fetus presenting by the vertex, culminating in the mother and infant being in good condition following birth (WHO 1999 as cited in Marshall & Raynor 2014).

According to Ojo and Brigg, labour is defined as the process by which the uterus empties its contents after the 28th week of pregnancy .It entails the contraction and retraction of the uterine muscles fibres ,the dilatation of the cervical os and the expulsion of the baby ,liquor amnii ,placenta and membranes .It also states that through a continuous process ,labour is divided into three stages for descriptive purposes and they are:

First stage of labour; from the onset of regular uterine contractions to full dilatation of the cervical os.it lasts 12-14 hours in primigravida and 6-12 hours in multigravida.The first stage of labour comprises: painful uterine contractions, progressive dilatation of the cervix,formation of the forewaters and rupture of membranes.

Second stage of labour; starts from full dilatation of the cervical os to the complete expulsion of the baby. It usually last up to1 hour in primigravida and 5-30 minutes in multigravida. Strong uterine contractions, descent through the pelvis, and the birth of the child are the features of the second stage of labour.

Third stage of labour; entails complete expulsion of the placenta and membranes,usually within 5-15 minutes of birth of the infant. The other feature of the 3rd stage,apart from the detachment and expulsion of the expulsion and the control of bleeding.

Also according to the GHS(2008), the goal of care during labour and delivery is to ensure the most positive outcome namely a healthy mother and healthy baby.

The specific objectives are:

- Proper management of the four stages of labour,and
- Early identification and proper management (treatment and/or referral complications.

Marshall and Raynor (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 toKonar (2013), under rest and ambulation; if the membranes are intact, the patient is allowed to walk about. This attitude prevents venacaval 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.

Also Konar (2013) further went on to state that, assessment of progress of labour and partograph recording are also done. Partographs are tools that allow labour progress to be graphically recorded and visually assessed. They aid in the early detection of abnormal labour progress and are credited by some for decreasing 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.

PUERPERIUM

Marshall and Raynor (2014) stated that puerperium starts immediately after the delivery of the placenta membrane and continues for six (6) weeks. In many cultures around the world 40 days for recuperation is a time-honored practice (Hundt et al 2000; Waugh 2011). The general expectation is that by six weeks after birth all the systems in a woman's body will have recovered sufficiently from the effects of the pregnancy and recovered to their non-pregnancy state.

According to Ojo and Briggs (2006)also said puerperium is a period of six to eight weeks postpartum in which the uterus, the genital organs and any other organs which underwent changes during pregnancy return to their pre-gravid state. According to them, this process or re-adjustment is called involution and that during that period lactation is also established. From the various points of view of the above authors, it maybe deduced that, puerperium is a period of six weeks which begins soon as the placenta is expelled. At this stage all the organs

and other structures that under gone changes during pregnancy return to their non-pregnant state. The management which the mother and baby required during puerperium are based on three principles; Promoting physical and physiological well-being of mother and baby, encouraging good infant feeding and maternal to child relationship and supporting and strengthening the mother`s confidence to enable her to fulfil her mothering role within her pregnant state, lactation is established, and mother recovers from the stress of pregnancy and labour.

Tiran (2008), stated that puerperium is the period from 6-8 weeks following child birth during which the uterus and other organs and structures are returning to their non – pregnancy state.

GHS (2008), also described puerperium as the period from the end of delivery to six weeks after delivery. He states further that the purpose of post –natal care is to maintain the physical and psychological wellbeing of the mother and the child. It includes education to the mother in the care of her child, detecting and treatment of referral of any abnormality for further management. The essentials of post-natal care are therefore:

1. Comprehensive screening to detect complications to both mother and child.
2. Treatment of complications in mother and baby.
3. Assessment and support for the infant feeding
4. Malaria and anemia prevention
5. Health education and counseling
6. Family planning counseling
7. Immunization services for mother and baby;

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

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

Konar (2013) 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.

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 statesthat it has been traditional to associate afterpains with multiparity and breastfeeding. However, women experience afterpains regardless of whether they have had previous pregnancies and when they are not breastfeeding. Management of afterpains is by an appropriate analgesic.

The American Academy of Paediatrics (2014) cited in their provider guide: Essential Care for Every Baby that all babies must be given eye care by instillation of tetracycline/chloramphenicol eye drops/ointment to prevent eye infections and also administering of vitamin k injection to prevent haemorrhage disease of the newborn as well as cord dressing.

From the above definitions, it can be deduced that, puerperium is the management of the mother and baby to exclude puerperal sepsis, other complications and establishment of lactation.

WHY CLIENT WAS CHOSEN

First contact with Madam Baah was on the 26th November 2020, during one of her scheduled antenatal visits at the Jinijini health center. Client was 36 weeks pregnant at the time of the visit. Client was selected during the health education session on birth preparedness and complication readiness plan. Client was active and contributed to the discussion.

During physical assessment, a glance at her antenatal book recorded that she had one previous delivery at the Jinijini Health Center. Client was a regular attendant to the antenatal clinic and was therefore chosen to encourage, motivate and ensure that she prepared well for the delivery and delivers at a health center when her time is due even though she had knowledge about birth preparedness.

Client had a good obstetric history and immediate introduction of self was made as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum on clinical practice. She was informed that she would be taken as a client for care study and nursed during her pregnancy, labour and puerperium. Client was pleased to be used for the care study and readily agreed to it. All questions asked by client regarding the process were answered and all doubts cleared. She was thanked for her cooperation. The midwife in charge was informed about the selected client and she gave her permission.

Phone numbers were exchanged and direction to her house was given for home visits. Appointment was booked for home visits.

CHAPTER ONE

CLIENT PARTICULARS

1.0 INTRODUCTION

This chapter provides detailed information about client social history, family history, medical history, surgical history, past and present obstetric history and also client lifestyle and the community as a whole.

The various information helps the health worker to render the most appropriate care to the client.

1.1 PERSONAL/ SOCIAL HISTORY

Madam Patricia, thirty- eight years, gravida three para two all alive is the client selected for the care study. She comes from Dormaa Ahenkro and lives at Jinijini, house number GCA0060 near Jinijini health Centre, Berekum West in the Bono Region of Ghana.

She is fair in complexion, with height 163cm and weight 57kg which was taken during her first visit to the clinic.She speaks English and Twi.

Madam Baah completed her junior high school at Catholic J.H.S at Dormaa Ahenkro.She then furthered her education at Dormaa senior high school at Dormaa Ahenkro.She is a teacher by profession. She is a good Christian and fellowship with Oasis of Liberty church at Jinijini. Madam Baah's next of kin is her husband, Pastor Baah. She does not engage in smoking and alcoholism.

1.2 FAMILY HISTORY

Madam Patricia mentioned that, there is no history of hereditary diseases such as hypertension, diabetes, asthma, sickle cell anemia, epilepsy or mental illness in her or that of

her husband's family. She further narrated that there is no history of multiple pregnancy in both families.

Madam Patricia is the second born of five children, two of them are males and the rest are females all alive in good health.Madam Emma Gyamea and the late George Gyabeng are the Parents of Madam Patricia.

1.3 SURGICAL HISTORY

Madam Patricia has never undergone any surgical procedure, neither has she been involved in an accident that might have affected her spine or her pelvic bone.On observation no scar was seen which could indicate previous surgery.

1.4 MEDICAL HISTORY

Madam Patricia has never complained or being diagnose of any serious illness aside slight headache which was as a result of stress from daily activities. She receives medical treatment as an outpatient when she suffers minor illness from Jinijini health Centre or buys drugs from nearby pharmacy shop when she falls sick.

She has never being admitted to the hospital and also has never being transfuse before Madam Patricia has no history of hypertension, sickle cell, diabetes, asthma,glucose6phosphatehydrogen deficiency,mental illness or any heart diseases. She never had any reaction to food or any drug before.

1.5MENSTRUAL HISTORY

Madam Patricia had her menarche at the age of thirteen, she has her normal menstrual cycle of twenty eight days with a normal flow of normal dark red colour which last for five days with slight dysmenorrhea. Madam Patricia, still had a menstrual flow of five days with slight

dysmenorrhea even after her first delivery. She gave her last normal menstrual period as 15thMarch, 2020.

1.6 CLIENT LIFESTYLE AND HOBBIES

Madam Patricia is a responsible woman who takes care of her home before stepping out of her house. She normally wakes up as early as 5:30am to begin with her morning duties. She does her quite time every morning after that cleans the environment and other house chores. She baths her children and prepare them for school. She prepare for breakfast which is mostly porridge for her family.

She returns from school around 3:00pm to pick up her children from school and return home to prepare supper. However, because of the covid 19 pandemic, she is always at home with her children. She uses Saturday mostly for her house chores and her laundry and cleaning of the house. She goes to church on every Sunday with her family at Oasis of Liberty church. She usually read the bible and tells bible stories to her children during her leisure time and goes to bed around 8:00pm.

1.7 PAST OBSTETRIC HISTORY

Pregnancy

Madam Patricia G3P2, carried her previous pregnancies till full term without any complication. She has no history of previous abortion either spontaneous or induced. She had her first pregnancy in 2013 and the second one in 2016 making the interval three years but the interval between the second pregnancy and this current pregnancy is four years.

According to her, she had no history of pregnancy induced hypertension, antepartum haemorrhage, diabetes in pregnancy and anaemia. She also experienced minor disorders like waist pains, pytalism,heart burns and leg cramps which was explained to her as normal

physiology in pregnancy more especially in early pregnancy and will resolve as pregnancy advances. She was given her first, second and third tetanus diphtheria injection during her previous pregnancies according to her antenatal book and her five doses of sulphadoxine pyrimethamineas usual in each pregnancy. She was a regular attendant at the antenatal clinic. Records for laboratory investigations were all good. She tested HIV negative

Labour

Madam Patricia said all her children were delivered spontaneously per vaginum at Jinijini health center without any complications like prolong second stage of labour or maternal distress amongst others. Also in all her births, she had no history of retained placenta or postpartum hemorrhage. According to her, all her babies were in good condition and cried immediately after birth. Client said she had a female as her first child and a male as her second child and their weights at birth was 2.9kg and 2.7kg respectively. The duration of labour for the first pregnancy exceeded 12 hours but did not exceed 18 hours since it was the first pregnancy.Second pregnancydid not exceed 12hours. The estimated blood loss for the first pregnancy was 200 milliliters and 150 milliliters respectively. Babies cried soon after delivery according to client. She had no complication after delivery, no abnormality or congenital malformation such as cleft lip, cleft palate or extra digit.

Puerperium

Madam Patricia went through puerperium safely without any complications such as postpartum haemorrhage, puerperal psychosis or puerperal sepsis but experienced some after pains which resolved within few days and her babies were able to suck soon after birth.Both children are healthy and in good health,and were fully immunized against the vaccine preventable diseases. She also performed exclusive breastfeeding for six months and weaned both children at two years. She was supported by her husband and mother till she was fully

recovered. Madam Patricia attended postnatal visits and was educated on family planning and the importance of child welfare clinic and also personal hygiene on her and the baby especially the baby to prevent any infection to the new born. According to Madam Patricia, she depends on natural family planning.

1.8 PRESENT OBSTETRIC HISTORY

Madam Patricia G3P2, all alive visited the health center on 11th June 2020.Client gave her last menstrual period(LMP) as 15th March, 2020 hence her expected date of delivery(EDD) was calculated as 22nd December, 2020.Vital information was taken and recorded during her first visit, which is booking. Vital signs and laboratory investigation were checked and recorded as follows;

Temperature 36.8 degrees celcius

Pulse 101 beats per minutes

Blood Pressure 100/60 millimeters of mercury

Weight 57 kilograms

Height 163 centimeters

Respiration 25 beats per minutes

The following laboratory investigation were also conducted and recorded as;

Haemoglobin 12.2g/dl

Sickling Negative

Blood group B

Rhesus factor Positive

VDRL Non-reactive

HIV /AIDSNegative

Hepatitis B Negative

G6PD No defect

Stool R/E No abnormalities detected

Urine (glucose and protein) No abnormalities detected

Physical examination was done to detect any abnormality but there was none, symphysio-fundal height and fetal heart was absent since it was at it early stage. Presentation and decent had not taken place.She was given her fourth dose of Tetanus Diphtheria (TD)injection since she had already taken her three doses in her previous pregnancy. She had no complains and was put on routine drugs;

Tablet folic acid 5milligrams daily for 30 days

Tablet multivitamin 200milligrams daily for 30 days.

Tablet fersolate200 milligrams daily for 30 days

She made her routine visits regularly,no abnormality were detected, laboratory investigation, ultrasound scan requested were carried out with no abnormalities recorded. She received her sulphadoxine Pyrimethamine when she was 20 weeks pregnant and it was repeated at 4 weeks interval. All findings were recorded in her ANC card.

CHAPTER TWO

ANTENATAL CARE

2.0 INTRODUCTION

This chapter contains more information about first contact with client, antenatal home visit, and subsequent visit to the clinic. It also contains care plan drawn to help meet the needs of the client and help solve the problems detected during the period of her antenatal care.

2.1 FIRST CONTACT WITH CLIENT

First contact with client was on 26th November,2020during one of her antenatal visit at Jinijini health center.Client was 36 weeks pregnant at the time she was met at the health center.She was attending her 8th antenatal visit.Having glanced through her antenatal book, it was realized she had no complication and will be suitable for the care study. An introduction was madeto her as a student midwife from Holy Family Nursing and Midwifery Training College, Berekum who is interested in selecting her for a studythroughout her pregnancy, labour and puerperium.

Client readily accepted and answered every information needed from her for the study. The midwife in charge agreed and gave her consent.

Her vital signs were checked and recorded as;

Temperature 36.8 degree celcius

Pulse 84 beats per minutes

Respiration 21 beats per minute

Blood pressure 110/70millimeters per mercury.

Weight 64kilograms

Laboratory investigations were also done and recorded as follows;

Haemoglobin	11.4 g/dl
HIV	Negative

Urine Testing

Madam Patricia was given a specimen bottle to provide a midstream urine to test for protein and glucose in the urine. The urine was amber in colour. The urine reagent strip was dipped inside the urine and both result were negative.

Both protein and glucose were negative which showed there was no traces of protein and glucose in her urine and that was a good sign,she was therefore encouraged to continue to take in more water to make the result good anytime she visit the health center.

After that, client was examined from head to toe through the following procedure;

General Head to Toe Examination

Client was asked to go to the examination room where privacy was provided properly.Permission was sought to conduct the procedure. Permission was granted and she was assisted to lie on the examination bed after undressing. She was told to lie on her left side before lying supine and was encourage to do that anytime she comes for antenatal care and even at home.

Hands were washed properly under running water with soap and dried with clean towel. Hands were rubbed together to keep it warm to prevent inducing any premature contraction.

The head was first inspected. Madam Patricia hair was checked for dandruff, breakages, cleanliness, her hair was well kept with no abnormalities. Client was encourage to always keep her hair clean.Face was checked for oedema and also chloasma but none was

detected.Client ears were then checked for any discharges but there was none detected.Client eyes were inspected for redness, conjunctiva checked for anaemia and sclera for jaundice.There was no abnormality detected.Mouth was inspected for cracked lip, halitosis, and tongue for pallor, there was no problem with the mouth, everything was good.The neck was palpated for distended veins, enlarged lymph nodes but all was in good order.

Breast examination procedure was explained to Madam Patricia and permission was granted.Breast was exposed and checked for size, shape and signs of pregnancy.She was asked to place the arm of the side that is to be examined first, that is the part that is farther from the midwife at the back of her head.The inner finger was used to palpate the breast inside out in a circular manner more important the axillary tail of Spence (breast tissue that extend to the axillae). Nipples were squeezed gently for fluid and cleaned with a cotton wool to see fluid. The same procedure was performed on the other side and client was advice to do it more often at home and if anything abnormal is detected, she should not hesitate to report to the health center.

Madam Patricia's hands were inspected for oedema, pallor of the palms .The finger nails and the nail bed for capillary refill and everything was normal.The lower extremities was checked for oedema especially the feet. The calf was palpated for tenderness and none was detected.She was encourage to avoid prolong standing and should rest her legs on a short table or a short chair when sitting down to prevent swelling of the feet.

The back was inspected for deformity of the spine (scoliosis) but there was none, the skin had no rashes and there was no tenderness of the coasto vertebra angle as well as oedema of the sacral region.

Abdominal Examination

Permission was asked to expose her abdomen for inspection after assisting her to lie on her back. The abdomen was examined to detect any deviation from normal standing on her right side. Items used for the examination were shown to her to allay fears.

A quick **inspection** was done on the abdomen without touching. The abdomen was observed to have an ovoid shape and medium in size.No scars was found to indicate any previous surgical procedure or caesarean Section. There were presence of linea niggra and striae gravidarum. Client said she felt fetal movement.

Measurement of Symphysio Fundal Height, before measuring the Symphysio fundal height, hands were rubbed to keep it warm. The upper part of the uterus was first palpated to locate the fundus(upper part of the uterus). After locating the fundus, zero part of the tape measure was placed on the fundus and was extended along the midline of the abdomen to the upper part of the symphysis pubis.It was recorded in centimeters and the measurement was 35cm at that time.

Fundal palpation,the palms were warmed after explaining procedure to the client.The client was faced and the fingers were curved around the top of the uterus to know what part lies in the upper pole of the uterus (fundus).The part felt was soft which indicate that, it was the buttocks.

On Lateral Palpationhands were placed on each side of the uterus, midway between the symphysis pubis and the fundus, the uterus was stabilized with one hand and examined with the other and the entire area from the abdominal midline to the lateral side and from the symphysis pubis to the fundus was palpated in a rotational manner. A smooth curve was felt which indicated the back at the right side of the abdomen, the process was then repeated on

the left side of the abdomen and an irregular mass and movement were felt which indicated the limbs.The position was therefore right occipito anterior.

Pelvic Palpationthis palpation is done to identify the presentation of the fetus. And also to check for descent of the head. Madam Patricia's feet were faced and was asked to bend the knees slightly in order to t relax the abdominal muscles and breath through her mouth slowly. The palms were placed on either side of the uterus just below the umbilicus and the fingers curved towards the symphysis pubis. A hard mass was felt at the lower pole of the uterus indicating the head.

Descent by pelvic palpation,descent was assessed. Two fingers were placed over the anterior shoulders and it was below the umbilicus. The upper boarder of the symphysis pubis was located and the right ulna was placed just above the symphysispubisand the palm extended to the anterior shoulder. Five fingers were accommodated, that is five fifth ($5/5^{th}$).

Vulva and Perineumclient's permission was sought for vulva examination and she accepted. Hands were washed with soap and water and dried with clean towel, clean examination gloves were worn on both hands, the vulva and the perineum was examined for abnormal discharges, rashes, and previous episiotomy scars and varicose veins. And nothing abnormal was detected.Madam Patricia was thanked for cooperating throughout the procedure and findings were communicated to her and documented as well after assisting her out of bed and redressing.Equipment used for the procedure was decontaminated properly. Gloves were removed and hands were washed properly under running water with soap and dried with clean towel.Client was encouraged to have enough rest and sleep and also perform exercise such as kegel exercise which strengthens the pelvic muscles and make delivery easy. Client was also encouraged to take her drugs asshe was told.Health education was given on birth preparedness and complication readiness plan. No complaints were made.

The following drugs were given to Madam Patricia;

Tablets multivitamins 200mg once daily for 7 days.

Tablets folic acid 5mg daily for 7 days

Tablets ferrous sulphate200mg once daily for 7 days

Client was informed of her next antenatal visit which was 3rdDecember, 2020 since she was 36 weeks. A schedule for home visit was planned and phone numbers were exchanged as well as client address was taken. Clients was reminded to report any problem and was told the danger signs of pregnancy.

2.2 FIRST ANTENATAL HOME VISIT

The first visit to Madam Patricia's house was on the 27th November, 2020 at exactly 4:30pm as was planned. The purpose of the visit was to observe client's environment, establish rapport with client's family and neighbors, assess client health status and offer a comprehensive focus antenatal care to client. The journey was made by foot and it was near Jinijini health center. A warm reception was made and was introduced to her family. A quick assessment of the environment was done after which a seat was offered. Client live in their own house with her family thus, her children and her husband.The house was built with blocks painted with white and brown colour roofed with iron sheet and contained three rooms with one kitchen, a bathroom and atoilet. The floors of the rooms were cemented and covered with carpet and the windows made with woods. Madam Patricia and her husband sleep in one room whiles their children occupied another room and slept under intermittent treated mosquito net, while the other room wasused as a guest room for visitors. The house has electricity as the source of power. Each room has two windows which could be opened for ventilation.

The family has a medium size basket covered with a plastic lid into which they put their waste and later emptied at the refused dump every morning. They use pipe born water from a nearby house about three minute walk from their house and store the water in a plastic container covered with a lid. Health education was given to the client and her family on birth preparedness and complication readiness plan, infection prevention and good nutrition even though she have an idea on it. Client's layette was inspected and all items such as baby's cloths, cot sheet, baby napkins or diapers, new clothes, etc was intact. Client had the telephone number of a taxi driver who will bring her to the facility incase her husband is not around when she was due, and support person was also identified as her close friend who live next to their house. Client complained of heartburns when asked and was advice to reduce intake of spicy foods and also to take in more water. Client was asked to bring her layette for inspection and it was complete.

2.3 SECOND ANTENATAL HOME VISIT

The second antenatal home visit to Madam Patricia's house was on the 11th December, 2020 at 4:00pm as scheduled. The purpose of the visit was to inquire about their health. A warm reception was given. An enquiry was made about the client and her family's health status and a positive response was given. However, client complained of headache and constipation. Client was encourage to do minimal work and also the family members was advice to help in house chores. On complain of the backache, Madam Patricia was told that it was as a result of the growing uterus causing a change in the posture and the influence of the hormone (relaxin) which relaxes the ligament. Client was encouraged to sleep on a firm surface to maintain a good posture when sitting and standing, and supports her back with pillow when sleeping and sitting. Client was again educated on the true signs of labour such as appearance of 'show', regular rhythmic painful uterine contractions and spontaneous rupture of membranes. Client was asked to report to the clinic any time she sees any of the signs mentioned to her. Client's

environment was clean and tidy and the refuse had been emptied. Inspection of the client's rooms was done and it was observed that the mosquito nets were well hanged.

Madam Patricia was reminded of the next visit to the clinic on the 17th December, 2020. She was thanked and bid fare well.

2.4 THIRD ANTENATAL HOME VISIT

The third antenatal visit to Madam Patricia's house was on the 19th December, 2020 at 5:00pm as planned. The motive of the visit was to inquire about her health status and the preparations made towards giving birth because her time was drawing closer. A warm reception was given and was made comfortable at home. An enquiry was made about client's health status and a good response was given. Client also said the whole family was doing well. Client however complained of having backache and sleep disturbances.She was therefore advised to support her back with pillows when sitting or sleeping and was explained to her as a result of the growing foetus and also descent of the presenting part. On complain of the sleep disturbances, client was encourage to empty her bladder before going to bed to avoid waking up to micturate. Education was given on personal hygiene to prevent infections. Client was again educated on the true signs of labour such as appearance of 'show', regular rhythmic painful uterine contractions and spontaneous rupture of membranes and that she should report any of that signs if she sees it on her.Client's environment was clean and tidy and the refuse had been emptied. Inspection of the client's rooms was done and it was observed that the mosquito nets were well hanged.

Madam Patricia was told to put her antenatal book in her bag anytime she goes out. She was again reminded of her next visit to the clinic on 24th December, 2020. She was thanked for her co-operation and bid fare well.

2.5 SUBSEQUENT VISIT TO THE CLINIC

On the 3rdDecember 2020, Madam Patricia came to the health center, which was the 2ndcontact with her at the clinic but her eight (9th) visit to the clinic. Client was welcomed and offered a seat. Madam Patricia was asked about her general condition and she confirmed she was doing well. Every procedure that was going to be carried on her was explained to her. Client's vital signs and weight was checked and recorded as follows;

Temperature 36.5 degree Celsius

Pulse 80 beat per minute

Respiration 22 beats per minute

Weight 65 kilograms

Blood pressure 120/80 millimeters of mercury.

Client's blood Haemoglobin level was checked and recorded as 12.4grams per deciliter. Client was asked to empty her bladder to promote comfort during physical examination and sample of the urine was tested for protein and glucose which tested negative. Hand washing was done with soap and under running water and dried with a clean dry towel before head to toe examination was done. Privacy was provided and she was assisted unto the examination bed in a dorsal position after undressing. On physical examination, everything from head to toe was normal. On fundal palpation, the buttocks of the foetus occupied the upper pole of the uterus (fundus).The lie was longitudinal, the back of the foetus was felt on the mother's right side and, the limbs on the left side, the position was right occipito anterior. The head occupied the lower pole with descent of 5/5th; symphysio fundal height was 36cm and gestational age was 37weeks. On auscultation, foetal heart was 138bpm. All findings were communicated to her. Client complained of heartburns and fatigue. Client was reassured and educated on the causes and prevention of heart

burns. Client was encouraged to avoid going to bed immediately after meals and elevate the top part of the bed when lying down. Client was again encouraged to reduce the intake of fatty and spicy food. Client was also asked to come back in a week time for review that was 10thDecember, 2020.Madam Patricia was thanked for her cooperation.

Routine drugs were given to her as usual which included:

Tablets multivitamins 200mg daily for 7 days

Tablets folic acid 5mg daily for 7 days

Tablets ferrous sulphate 200mg daily for 7 days.

2.6 SUBSEQUENT VISIT TO THE CLINIC BY THECLIENT

On 10th December, 2020 Madam Patricia visited the clinic. Client was welcomed to the clinic and a seat was offered to make her feel comfortable. Client was asked of how she was doing and about her family too and she said everyone was doing well. Her vital signs were taken and it was recorded as:

Temperature	36.4^0C
Pulse	80bpm
Respiration	20cpm
Blood pressure	100/70mmhg
Weight	66kilograms

The investigations are indicated as follows:

Urine for protein and sugar	negative
Hemoglobin	12.4g/dl

She was then sent to the palpation room. Procedures to be performed on her were explained and permission was sought. She was asked to empty her bladder to make the examination more accurate and was position on the couch. Hand washing was done with soap under running water and dried with a clean towel. Head to toe examination was done and no abnormality was detected. On abdominal inspection, the abdomen was ovoid in shape with linea niggra present. On palpation symphysio fundal height was 37cm, gestation was 38 weeks, lie was longitudinal and presentation was cephalic, descent was 5\5th and on auscultation fetal heart rate was 138 beats per minute, everything was normal. She was thanked and was helped from the examination bed. Findings were communicated to her. She was then educated on good nutrition. Routine drugs were given to her as usual which included:

Tablets multivitamins 200mg daily for 7 days

Tablets folic acid 5mg daily for 7 days

Tablets ferrous sulphate 200mg daily for 7 days

The next antenatal visit was scheduled for 17thDecember, 2020 if client had not delivered. Madam Patricia was thanked and bid fare well.

2.7SUBSEQUENT VISIT TO THE CLINIC

On the 17th December, 2020 Madam Patricia visited the clinic. She was warmly welcomed and a seat was offered to her. She was asked how she was faring and said she was fine. Her weight was 67kg whiles her haemoglobin was 12.6grams per deciliter. Her vital signs were checked and recorded as;

Temperature	36.6 degree celcius
Pulse	69 beats per minutes

Respiration	19 cycle per minute
Blood pressure	110/70mmHg
Weight	67 kilogram

The investigations are indicated as follows:

Urine for protein and sugar	negative
Hemoglobin	12.6g/dl

Sample of her urine was taken and checked for protein and glucose and they were all negative.All procedures to be carried out on her were explained to her and privacy was provided. Hand washing was done with soap under running water 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 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 $5/5^{th}$. The symphysio fundal height was 38cm with a fetal heart rate of 140beats per minutes and the gestational age was 39 weeks. All findings were communicated to her after the procedure and she was thanked for her co-operation. She was asked whether she had any complains and she complained of backache. She was reassured and told that the pain was as result of effect of the hormones progesterone and relaxin which relaxes the pelvic ligaments and muscles. She was advised to maintain a straight back when even lifting light objects and also to get a hard board under her mattress for a firm back support. Routine drugs were given to her as follows;

Tablets multivitamins 200mg daily for 7 days

Tablets folic acid 5mg daily for 7 days

Tablets ferrous sulphate 200mg daily for 7 days

The next antenatal visit was scheduled for 24th December, 2020 if client had not delivered.

Madam Patricia was thanked and bid fare well.

2.8 NURSING CARE PLAN

Problems Identified during Antenatal

- 27/11/20 heartburns
- 11/12/20 headache
- 11/12/20 constipation
- 17/12/20 Backache
- 19/12/20 sleep disturbance

Short Term Objectives

- Madam Patricia will cope with reduced episodes of heartburns within 24 hours.
- Client headache will resolve within 24 hours.
- Client will have free bowels within 48hours
- Client will have reduced episodes of backache within 24 hours.
- Client will have at least six (6) hours of sleep daily within 24 hours.

Long Term Objectives

Madam Patricia will go through pregnancy safely without any complication.

TABLE 1: NURSING CARE PLAN DURING ANTENATAL CARE

Date/ Time	**Nursing Diagnosis**	**Nursing Objectives/Outcome Criteria**	**Nursing orders**	**Nursing Intervention**	**Date/time**	**Evaluation**	**Sign**
27/11/20 12:00pm	Heartburns related to the relaxation of the cardiac sphincter of the stomach with reflux of acidic contents of the stomach into the lower esophagus.	Client will cope with reduced episodes of heartburns within 24 hours as evidenced by: 1. Client verbalizing that the intensity of heart burns has reduced.	1.Reassure client 2.Educate client on the causes of heartburns 3. Encourage client not to go to bed immediately after meals. 4. Educate client to elevate the head end of the bed when sleeping. 5 .Educate client on diet.	1 .Client was reassured that the intensity of heartburns would reduce. 2. Client was educated that it was due to regurgitation of gastric contents due to relaxation of the cardiac sphincter. 3. Client was encouraged to go to bed at least 2 hours after meals. 4. Client was educated to use more pillows when sleeping to elevate the head end of the bed. 5. Madam Patricia was encouraged to eat less spicy foods.	28/11/20 12:00pm	Goal fully met as the intensity of heartburns reduced.	

TABLE 2: CARE PLAN DURING ANTENATAL CARE

Date/ Time	**Nursing Diagnosis**	**Nursing Objectives/Outcome Criteria**	**Nursing orders**	**Nursing Intervention**	**Date/time**	**Evaluation**	**Sign**
11/12/20 2:00pm	Headache related to stress of pregnancy	Client`s headache will resolve within 24 hours as evidenced by client verbalizing that the pain has resolved.	1. Reassure client. 2. Explain cause of headache. 3. Educate client to have enough rest and sleep. 4. Encourage client to drink adequate amount of water. 5. Administer prescribe analgesics.	1. Client was reassure that headache will resolve. 2. Client was told it was due to stress of pregnancy. 3. Client was educated to have at least two hours rest during the day and six hours at night. 4. Client was encourage to drink at least 8 glasses of water every day. 5. Tab paracetamol 1g was served as prescribed.	12/12/20 2:00pm	Goal fully met as client said her headache resolved.	

TABLE 2: CARE PLAN DURING ANTENATAL CARE

Date/ Time	**Nursing Diagnosis**	**Nursing Objectives/Outcome Criteria**	**Nursing orders**	**Nursing Intervention**	**Date/time**	**Evaluation**	**Sign**
11/12/20 10:00am	Constipation related to increase progesterone level in the blood which causes relaxation of smooth muscles of the colon thereby causing decreased motility of the gut.	Madam Patricia will have free bowel within 48 hours as evidenced by 1. Madam Patricia verbalizing that she has being able to empty her bowel freely.	1. Reassure client. 2. Explain the physiology of the constipation to her. 3. Educate client to eat enough roughages and fruits. 4. Encourage her on the intake of fluids. 5. Encourage her to respond to the urge of emptying the bowel to avoid reabsorption of water from thestools.	1. Client was reassure that she will be able to empty her bowel freely. 2. She was told it was due to the effect of progesterone on her GIT. 3. Client was advice to eat enough roughages like fruits and vegetables. 4. Client was encourage to take at least 8 glasses of water a day. 5. She was also encourage to respond to the urge of emptying her bowel to avoid reabsorption of water from the stools.	13/12/20 10:00am	Goal fully met as client said she emptied her bowel freely.	

TABLE 2: CARE PLAN DURING ANTENATAL CARE

Date/ Time	**Nursing Diagnosis**	**Nursing Objectives/Outcome Criteria**	**Nursing orders**	**Nursing Intervention**	**Date/time**	**Evaluation**	**Sign**
17/12/20 10:00am	Backache related to exaggerated lumber curvature during pregnancy.	Client will have reduced episodes of backache within 24hours as evidenced by; 1. Client verbalizing that her pains is reduced.	1. Reassure client. 2. Educate client on the physiology of backache in pregnancy. 3. Advice client to have enough rest. 4. Educate client to support her back with pillow when sleeping or sitting. 5. Serve her prescribe analgesics.	1. Client was reassured that her pain would subside. 2. Client was educated that pain was as a result of the effect of the hormone progesterone and relaxin which relaxes the pelvic ligament and muscles. 3. Client was advised to have enough rest. 4. Client was educated to support her back with pillow when sleeping or sitting. 5. Prescribed paracetamol 1g was served tid.	18/12/20 10:00am	Goal fully met as Madam Patricia reported to the midwife that her back pains has reduced.	

TABLE 2: CARE PLAN DURING ANTENATAL CARE

Date/ Time	**Nursing Diagnosis**	**Nursing Objectives/Outcome Criteria**	**Nursing orders**	**Nursing Intervention**	**Date/time**	**Evaluation**	**Sign**
19/12/20 at 11:00 am	Sleep disturbances related to frequent micturition.	Client will have at least six hours sleep within 24 hours as evidenced by client verbalizing she slept for at least six hours.	1. Reassure client will have adequate rest and sleep. 2. Educate client on the physiology of frequent micturition. 3. Tell client to urinate before going to bed. 4. Educate client to limit the intake of fluid containing natural diuretics. 5. Encourage client to eat before 6pm.	1. Client was reassured of adequate sleep if interventions are followed. 2. She was educated that it was due to descent of the presenting part. 3. Client was told to urinate before going to bed. 4. She was also educated to limit the intake of fluids such as tea, caffeine at night. 5. Client was encourage to eat before 6pm.	20/12/20 at 11:00am	Goal fully met as client reported that she slept for six hours.	

CHAPTER THREE

LABOUR

3.0 INTRODUCTION

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

3.1 ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Admission

On 20th December 2020, Madam Patricia reported to the health center at 5:40am with complains of waist and lower abdominal pain as a result of painful rhythmic uterine contraction. Further enquiries made, indicated that client had seen blood stained mucus (show) at 2:30am at dawn but because it was late they waited till it was morning before reporting to the health center. She was accompanied by her friend who stays next to their house. They were welcomed and were offered seat and further assured that she is in safe hands. Her maternal health record book was taken and glanced through. She was asked if she had experienced any danger signs like bleeding, from her vagina, leakage of liquor and persistent vomiting. Madam Patricia replied that she had not seen any of the signs. She appeared anxious and she was told she was in competent hands and that she would have a safe delivery. Her expected date of delivery was confirmed which dated 22nd December, 2020. She was made comfortable in bed and all procedures to be carried out were explained to her and her consent was sought. Client's labour history was taken and recorded. Her haemoglobin level was checked and it was 12.4g/dl. Her vital signs were checked and recorded as follows:

Vital Sign	Value
Temperature	36.0 degree Celsius
Pulse	70 beats per minutes
Respiration	20 cycles per minutes
Blood Pressure	120/80 millimeters of mercury

A specimen bottle was given to client for the midstream urine collection for urine examination and a bed pan was also served. The amount of urine produced was 200mls. A urine reagent strip was used to test for glucose, acetone and protein and the result was negative and the colour of urine was amber, clear and not offensive. Hands were washed with soap under clean running and soap water and dried with clean dry towel. Client drank more water. Having explained the procedure and her consent sought, head to toe general examination was conducted but no abnormality was detected. The abdomen was inspected. On inspection**,** client's abdomen was ovoid in shape and medium in size. Striae gravidarum, linear niggra and fetal movement were present but no scar was found. The abdomen was palpated, symphysio fundal height was 38cm, and gestational age was 39 weeks, the lie was longitudinal, presentation was cephalic, and descent was 4/5 palpable abdominally. Contraction was 3 in10 minutes lasting for 30 second. On auscultation,the fetal heart rate was 138 beats per minute with good volume and regular in rhythm.

A sterile tray for vaginal examination was brought to the bed side and the procedure was explained to her. Madam Patricia was helped onto the lithotomy position at 6:00am. Hands were washed with soap under water and dried with a clean towel, sterile gloves were worn for vaginal examination. The vulva was then inspected for scars, sores, warts, edema, abnormal discharge but none was present.

The vulva was then swabbed with sterile cotton wool swabs soaked in savlon solution. After swabbing the vulva, the vagina was entered with the middle finger and then followed by the

index finger. On vaginal examination, the vagina was warm and moist, the cervix was soft, thin and the presenting part well applied to it. The membranes were intact, cervical dilatation was four (4) centimeters. Presentation was cephalic, promontory of sacrum was not reached. The sacrum was well curved, ischial spines were blunt and pubic arch was wide. Hands were removed and a fist was made and it fitted into the intertuberous diameter. Madam Patricia's perineum was cleaned and a perineal pad applied to the vulva.

Client was covered with a cloth and made comfortable in bed. She was also encouraged to ambulate which will help her deliver early and to lie on her left when she felt tired. Client was then informed about the findings and after this, findings were recorded. All procedures were done under the supervision of the midwife-in-charge and recorded on a partograph.

Preparation of birth

The midwife in-charge who was supervising the labour was chosen as a skilled helper. The friend of the client who was the unskilled helper was informed to be available in order to run errands when needed. The taxi driver was also informed that his service may be needed when there is emergency The delivery room was prepared for delivery; the room was made clean and warm by drawing the curtains closer, testing of light and making provision for artificial lighting and switching off fans. Madam Patricia's abdomen was washed and dried to prevent infection to the baby after delivery since the baby will be placed skin to skin on the mother's abdomen. She was assisted to wash and dry her hands.

It was ensured that resuscitaire was clean and prepared for resuscitation when necessary. The equipment needed for resuscitation were assembled and tested for functioning and they were in good condition. The equipment included head cover, scissors, ambo bag and mask, timer, suction device, stethoscope, source of light.

Management of first stage of labour

Client was put on partograph on admission when labour was established. Fetal heart rate, contractions and pulse were checked every 30 minutes and vaginal examination, descent, blood pressure and temperature was done four hourly. She complained of tiredness and was reassured and encouraged to avoid screaming and perform deep breathing exercise when there are contractions. She was encouraged to take light nutritious diet and normal fluids in bits to prevent dehydration and to help her during the second stage of labour. She took a cup of porridge. Madam Patricia was also encouraged to adopt left lateral position to prevent supine hypotension syndrome. She complained of thirst and dry throat. She was then encouraged to take sips of water to quench her thirst and to keep her mouth and throat wet. At 10:00am membranes ruptured and client complained that she wants to defecate. Vaginal examination was done to exclude cord prolapse and to confirm full dilatation of the cervix and client was 8cm dilated with no moulding, clear liquor and descent was $1/5^{th}$, contractions were 4 in 10 lasting 35 seconds fetal heart rate was 142bpm. Delivery trolley was set up.

The top shelf:

- Cord scissors
- Cord clump
- 2 artery forceps
- 2 cot sheet
- Vitamin k injection
- Episiotomy set
- 4 drapes
- 10 units of oxytocin
- Pair of sterile gloves

- 2 gallipots (one containing cotton swabs soaked in savlon solution and the other containing gauze)

Bottom shelf

- Measuring jag
- Placenta bowl
- Sucker in a bowl of water
- Bed pan
- Rubber mackintosh
- Rubber apron
- Extra sterile gloves.

At 12:40pm, Madam Patricia shouted, she had the edge to pass stools, vaginal examination was done and the cervix was 10cm dilated, liquor was clear and moulding was ++ descent was $0/5^{th}$, contractions was 5 in 10 minutes lasting 45 seconds and fetal heart rate was 140 bpm the perineum bulged and the anus gaped. The midwife in-charge was informed of the progress of labour and was asked to confirm it and she confirmed, which marked the beginning of second stage of labour. The first stage lasted for 6 hours.

3.2 MANAGEMENT OF SECOND STAGE OF LABOUR

Second stage of labour begins from full dilatation of cervix to the birth of the foetus. After carrying out vaginal examination, client was informed that she was due to deliver her baby.

Madam Patricia was asked about the position she preferred to deliver her baby with and she assume the lithotomy position. All windows were closed and fans were turned off. Protective clothing were then worn, that is plastic apron, boots and face masks. Delivery pack was opened and after which sterile gloves were worn.

The vulva was cleaned with cotton wool balls soaked in savlon solution. She was draped with sterile sheets on both thighs, on the abdomen and under the buttocks to maintain a sterile field for the foetus. Madam Patricia was reminded that the baby would be delivered onto her abdomen and she agreed. With the second stage being confirmed by the last vaginal examination, she was asked to push with contractions and take a rest when the contractions wear off.

As she pushed and the head was advancing, a clean perineal pad was placed at the anal region to prevent the stool from contaminating the delivery field and getting in to contact with baby's face.

The middle and index fingers of the right hand were placed on the fetal advancing head to aid flexion and to allow the smallest diameter of the fetal head to distend the vulva; this was done to prevent crack or tear of the perineum. With contractions crowning took place and the woman was asked to pant with contraction in order to prevent sudden expulsion of the fetal head. Extension of the head occurred in which sinciput, face and chins swept the perineum and the head was born. The eyes were cleaned immediately with sterile gauze, cleaning from the inner contour of the eyes outward using a swab at a time.

The neck was felt for cord around it and there was none. Restitution occurred and external rotation of the head which indicates that internal rotation of the shoulders had occurred. The fetal head was held in both palms, each palm on the parietal bones and with little downward traction, the anterior shoulder was delivered. The posterior shoulder was also delivered with upwards traction as it was allowed to sweep the perineum and with lateral flexion, the trunk and the rest of the body was delivered onto the mother's abdomen. The sex of the baby was noticed to be a female and the client was allowed to confirm

The baby coughed and started crying out very loudly. The baby was left on the mother's chest to initiate bonding, breast feeding and to provide warmth. The baby was completely expelled at 12:50pm.

3.3 IMMEDIATE CARE OF THE BABY

Immediately the head was delivered, sterile gauze was used to clean the baby`s eyes from inner canthus outwards. As soon as the whole body was delivered, the baby was placed on the mother's abdomen and dried thoroughly off liquor to prevent heat loss through evaporation. The first minute APGAR score was recorded as;

First Minute APGAR score:

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

Within 1-3 minutes, the cord was clamped 2cm away from the base and 3cm away from the first clamp and was covered with gauze and cut in- between the clamps to separate the baby from the mother.

The baby was made warm by wiping off the liquor and was left on the mother's abdomen for skin-to-skin to prevent heat loss and an identification band was placed at the baby's wrist with the mother's name, sex, date and time of delivery. The condition of the baby was very good as she was actively crying and responding to stimuli.

Fifth Minute APGAR score

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

3.4 ACTIVE MANAGEMENT OF THIRD STAGE OF LABOUR

This stage of labour deals with the total delivery of the placenta and membranes and control of hemorrhage.10 units of oxytocin was given intramuscularly at the thigh of Madam Patricia with the aim of contracting the uterus after palpating to exclude second twin.

Controlled cord traction was the method used in delivering the placenta in order to prevent retained placenta or products of conception. The cord was clamped closer to the perineum. A receiver was placed in between Madam Patricia's thigh to receive the placenta and membranes.

The left palm was placed on the uterus to feel for contraction. It was repositioned to the supra pubic area when contraction was felt, control traction was applied on the cord in a downward motion to deliver the placenta in the direction of the curve of carus. Steady traction was maintained until the placenta was visible at the vulva. The placenta was cupped in both hands and the placenta was twisted to deliver the placenta and its membranes.

The placenta and membranes were expelled completely at 12:55pm. The placenta was placed in the receiver after quick examination was done to know whether the membranes and lobes

were intact. The blood loss was approximately 130mls. The uterus was rubbed to stimulate contraction and expel clots. Client was taught how to perform uterine massage and also educated on how the uterus should feel after massaging. The perineum, vulva, vagina and the cervix were swabbed and examined for tears and lacerations under a good source of light but there was no tear. A clean pad was then used to clean the liquor and the blood from her body.

A clean perineal pad was also applied to the perineum and the client was asked to lie on her back and cross her legs so that any bleeding could easily be identified. She was thanked for her co-operation and efforts. She was informed to empty her bladder whenever she felt the urge in order to prevent bleeding.

Finally the placenta and membranes were sent to the sluice room to be examined and discarded afterwards as per the protocol of the facility. Placenta and membranes were immersed in 0.5% chlorine solution for ten minutes to minimize the risk of infection during examination.

3.5 EXAMINATION OF THE PLACENTA AND MEMBRANES

After the client was made comfortable in bed, the placenta was examined thoroughly in the sluice room and was 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 fitted together without any gab and edges also forming uniform circle at the maternal surface and this indicated there was no missing lobe, there were no white patches on the maternal surface, there was also no blood vessels radiating into the membranes which indicated absence of succenturiate lobe.

The cord was situated at the center of the placenta with one vein and two arteries. There was no abnormality detected. The placenta was discarded after decontaminating it according to the protocol of the facility.

The instruments and equipment used were soaked in 0.5% chlorine solution for ten minutes and washed, rinsed, dried and repacked for sterilization.

3.6 MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour is a period of close observation of mother and baby for the first six hours after delivery to detect any deviation from normal. Madam Patricia finished skin to skin at the labour room before being taken to the lying-in-ward for further observation to be carried out. This stage includes prevention of disease, examination of the new born, management of the mother's condition and the baby.

Baby

Prevention of disease

Two drops of Chloramphenicol eye drops was instilled on the baby's eye as prophylaxis for any eye infection. The baby was covered to provide warmth to prevent heat loss, vitamin K 1.0milligram was given intramuscularly on the thigh to prevent bleeding. Baby`s skin was smeared with baby oil to provide warmth.

Hands were washed and cord was dressed with chlohexidine. The baby was put to breast. She was further asked to report when she observes any bleeding, discharge and redness of the cord. Hands were washed with soap and water and dried with a clean towel.

Examination of the newborn

The procedure was explained to Madam Patricia. Baby's weight was 2.9 kilograms. Measurements of the baby were done and the head circumference 33 centimeters, length of the baby was 48 centimeters. Baby's vital signs were checked and recorded as follows;

Vital Sign	**Value**
Temperature	36.5degreeCelsius
Apex heartbeat	148 beats per minute
Respiration	38 cycles per minute

Examination gloves were worn and the baby was examined in the presence of the mother in a clean, warm environment, where nearby windows were closed. Baby was put on a covered flat surface and only the part to be examined was exposed. The general condition of baby was checked to be normal. The color was pink, chest was moving normally and the baby was active. A detailed head to toe examination was carried out to detect any abnormality.

The head and scalp were normal with no caput succedaneum, bulging or sunken fontanels. The eye balls were examined for jaundice, discharge and redness 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. No abnormality was detected. 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 also no false tooth noticed. The palate was high arched, intact and the vulva centrally placed. There was no cleft palate or cleft lip, or tongue tie. The ears were inspected, the upper notch of the pinnae was at the same level with 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. The neck was inspected and palpated with no swelling such as congenital goiter, enlarged lymph node, rotation and flexion were good .The chest was examined, the respiratory movement was regular and the respiratory rate was 38cpm. The space between the nipples was noted and the nipples were in alignment. The abdomen was round with no bleeding from the umbilical cord. The cord was examined and there was one vein and two arteries. Hands and arms were inspected for symmetry, movement and paralysis, and the palm for the number of palmer creases. Shape and color of nail beds were inspected for reflexes (grasping, Moro) and they were normal. Hands were again examined for clubbing, extra or missing digits, nail growth and webbing and no abnormality was detected.

The length and movement of the limbs were also noted. The digits were counted to be normal and separate to exclude webbing. The feet were examined for any disability such as talips equinovarus. The lower limbs were also examined for congenital dislocation of the hip but no abnormality was detected. The spine was also examined with baby lying in prone position. The back was palpated for swelling, dimpling, hairy patches to exclude spinal bifida.

In all, there was no abnormality detected. The baby was classified as normal and routine care of the baby initiated. 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. All findings were reported and recorded.

The genital area was examined and the vagina was inspected for patency and also any pseudo menstruation

Mother

Client`s vital signs as well as uterus and lochia were checked every 15 minutes for the first two hours, then 30 minutes for the third hour and hourly for the fourth, fifth and sixth hour's post-delivery. Madam Patricia's vital signs were checked and recorded as follows;

Vital Signs	**Value**
Temperature	36.4degreeCelsius
Pulse	82beatsperminutes
Respiration	20 cycle per minute
Blood pressure	100/60 millimeters of mercury

Client was asked to empty her bladder for fundal height to be measured and she was further informed that, emptying her bladder would provide comfort and ensure accurate measurement. Afterwards, a new perineal pad was applied on her vulva. She was helped to lie down comfortably.

The uterus was well contracted with symphysio fundal height measuring 18 centimeters. The lochia was red in color (rubra) and moderate in amount with no offensive odour. The baby was then put to breast to stimulate the release of oxytocin to aid in the contraction of the uterus and also to help in the passage of milk. Education was also given to her on the need to change her perineal pad frequently and any time it got soiled. She was encouraged to report any bleeding. She was further encouraged to eat any food of her choice.

She ate kenkey with okro. Her relatives were allowed to visit mother and baby. At 1:00pm the mother and her baby's vital signs and other examinations were carried out and recorded to know their condition.

3.7 SUMMERY OF LABOUR AND DELIVERY

Date of delivery	-	20th December, 2020
Time of delivery	-	12:50pm
Type of delivery	-	Spontaneous Vaginal Delivery
Time of placental delivery	-	12:55pm

Duration of labour

1st stage	-	6 hours 30 minutes
2nd stage	-	10 minutes
3rd stage	-	5 minutes
Total	-	6 hours 45minutes

Condition of baby

Apgar score at first minute	-	8/10
Apgar score at fifth minute	-	9/10
Sex of baby	-	Female
Weight	-	2.9kg

Head circumference	-	33cm
Full length	-	48cm
Meconium	-	Passed
Urine	-	Passed
Condition	-	Satisfactory

Condition of mother

Temperature	-	36.1degreeCelcius
Pulse	-	80beats per minute
Respiration	-	20 cycles per minute
Blood Pressure	-	120/70millimeters of mercury
Fundus	-	18centimeters
Lochia	-	Red (rubra)
Odour of Lochia	-	Non- offensive
Perineum	-	Intact
Condition	-	Satisfactory

Condition of placenta and membranes

Lobes and membranes	-	Complete and healthy
Maternal surface	-	Normal
Fetal surface	-	Normal

3.8 CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

On 22nd December 2020, Madam Patricia complained of;

- Waist and lower abdominal pains.
- Anxiety
- Thirst and dry throat
- Tiredness
- Poor maintenance and personal hygiene

SHORT TERM OBJECTIVES

- Madam Patricia will cope with lower abdominal pain and waist pain within 2hours.
- Client`s anxiety will resolve within 30 minutes.
- Client`s thirst and dry throat will resolve within 10 minutes.
- Client will regain her strength within 2 hours.
- Client`s hygiene will be maintained within 2 hours.

LONG TERM OBJECTIVES

Madam Patricia will go through labour and delivery successfully without any complications to mother and baby.

TABLE 1: LABOUR CARE PLAN

Date/Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
20/12/20 6:00am	Lower abdominal pains related to physiology of labour.	Madam Patricia will cope with lower abdominal and waist pains within 2 hours as evidence by 1. Client verbalizing that she is coping with labour pains 2. Midwife observing that client no longer complains.	1. Reassure her that labour will soon end. 2. Explain the physiology of labour pains to her. 3. Perform sacral massage for client. 4. Encourage client to do deep breathing exercise. 5. Provide diversional therapy. 6. Put client in a comfortable position.	1. Client was reassured that labour would soon end. 2. The physiology of labour pains was explained to her. 3. Client sacral region was massage by her support person. 4. Client was encouraged to perform deep breathing exercise. 5. Client was stayed with and engaged in a conversation. 6. Client was put in a left lateral position.	20/12/20 8:00am	Goal met as client said she was coping with the pain.	

TABLE 2: LABOUR CARE PLAN

Date/ Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Interventions	Date/Time	Evaluation	Sign
20/12/20 9:00am	Anxiety related to unknown outcome of labour.	Madam Patricia will be relieved of anxiety within 30 minutes as evidence by 1. Client verbalizing that she is no longer anxious. 2. Midwife observing that client is not anxious.	1. Reassure client. 2. Allow support person to be with her. 3. Allow her to ask questions and answer her tactfully. 4. Explain every procedure to be carried on client. 5. Update client with progress of labour.	1. Client was reassure that labour will end safe. 2. Client`s friend was allowed to her and massage her sacral region during contractions. 3. Client was allowed to ask questions and answers were given tactfully. 4. Procedures like checking of vital signs, vaginal examination were explained to client. 5. Client was updated with progress of labour using the dilatation board after vaginal examination	20/12/20 9:30am	Goal met as client said she was no more anxious	

TABLE 3: LABOUR CARE PLAN

Date/Time	Nursing Diagnosis	Nursing Objectives/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
20/12/20 11:00	Thirst and dry throat related to the process of labour.	Client`s thirst and dry throat will resolve within 10 minutes as evidenced by client verbalizing she is no longer thirsty.	1. Reassure client. 2. Explain the process of labour to the client. 3. Support the client to perform deep breathing exercise. 4. Give client sips of water. 5. Serve client with fluid diet.	1. Client was reassured that measures will be put in place to relieve her off her the thirst and dry throat. 2. Process of labour was explained to client. 3. Client was supported to perform deep breathing exercise during contractions. 4. Client was given sips of water and ice to suck. 5. Client was served with cold drink.	20/12/20 11:10am	Goal fully met as evidenced by client verbalizing she does not feel thirsty and dry throat.	

TABLE 4: LABOUR CARE PLAN

Date/Time	Nursing Diagnosis	Nursing Objective/Outcome Criteria	Nursing Orders	Nursing Intervention	Date/Time	Evaluation	Sign
20/12/20 10:00am	Tiredness related to advance state of labour.	Client will regain her strength within 2 hours as evidenced by the client verbalizing that she is relieved of tiredness.	1. Reassure client that she will be relieve of tiredness. 2. Encourage client not to scream during contractions. 3. Support client to perform deep breathing exercise during contractions. 4. Encourage client to continue with the relaxation technique. 5. Serve client with light diet.	1. Client was reassure that she will regain her strength. 2. Client was encouraged not to scream during contraction. 3. Client was supported to perform deep breathing exercise during contractions. 4. Client was supported to continue the relaxation technique. 5. Client was served with light porridge.	21/12/20 12:00pm	Goal fully met as client verbalizing she had been relieved of tiredness	

TABLE 5: LABOUR CARE PLAN

Date/Time	Nursing Diagnosis	Nursing Objectives/Outcome	Nursing Orders	Nursing Intervention	Date/ Time	Evaluation	Sign
20/12/20 10:30am	Poor personal hygiene related to advanced stage of labour.	Client will be able to maintain hygiene within 2 hours as evidenced by the midwife observing that client is clean.	1. Reassure client. 2. Wipe sweat off client`s face and body with wet towel. 3. Advice client to change her sanitary pad when soiled. 4. Change client soiled bed linen. 5. Encourage client to take cold shower.	1. Client was reassured that measures will be put in place to help her maintain her personal hygiene. 2. Wet towel was used to clean client`s face and body. 3. Client was advised to change her sanitary pad when soiled. 4. Client`s soiled bed linen was changed. 5. Client was assisted to take cold shower.	20/12/20 12:30pm	Goal fully met as evidenced by client looking clean and neat.	

CHAPTER FOUR

PUERPERIUM

4.0 INTRODUCTION

This chapter entails the day of delivery, subsequent care of baby, home visits, and first visit to the clinic as well as care plan for problem identified.

4.1 DAY OF DELIVERY

Madam Patricia was transferred to the postnatal ward after the one hour skin to skin contact on the 20th December 2020 where she was given a comfortable bed to sleep on. Both mother and baby were kept warm to prevent heat loss by closing doors, windows and baby was well wrapped.

Madam Patricia was educated on how to properly fix the baby to breast. She was advised to have enough rest and sleep. The following were her vital signs:

Temperature	36.0 degree Celsius
Pulse	78 beats per minute
Respiration	20 cycles per minutes
Blood pressure	111/72millimetres of mercury

The vital signs were checked every 15 minutes for 2 hours and 30 minutes for 1 hour and hourly for the next 3 hours after which it was checked for every 4 hours. Perineum was inspected for lochia which was red (rubra) with small flows and no odour. Symphysio-fundal height measured 18centimeters. She was served with porridge and bread.

4.2 SUBSEQUENT CARE OF BABY

After six hours, Madam Patricia was informed about the need for baby bath and general examination of the baby and she responded positively. Head to toe examination was done and no abnormality detected and then vital signs checked and recorded as:

Apex heart beat	120 beats per minute
Temperature	36.8 degree Celsius
Respiration	42 cycles per minute
Weight	2.9 kilograms

All findings were communicated to Madam Patricia.

BABY'S FIRST BATH AND CORD DRESSING

Requirements

1. Soap
2. Sponge
3. Cream/ powder
4. Sterile cotton in a gallipot or wrapped
5. Basin
6. Towels: 1 big towel and 3 small ones
7. Cot sheets 2
8. Apron
9. Gloves
10. A clean baby dress, cap and socks(if available)
11. Mackintosh

12. 2 jugs containing hot and cold water each
13. Two receptacles for used water and dirty linen
14. A receiver for used swab

Procedure

All windows and doors were closed, fans switched off and the lights switched on to make the room warm. Procedure was explained to Madam Patricia and was thanked for accepting. After gathering all items, the hot and cold water were mixed and temperature was tested with the elbow.

Plastic apron was then worn, hands were washed with soap under running water and dried with a clean towel. Sterile gloves were worn and the baby was positioned on a protected flat surface, she was undressed and covered with the towel leaving the face. The general condition was observed and baby had a pink skin colour covered with vernix caseosa. Baby's eyes were cleaned with cotton wool swab soaked in clean water from the inner canthus out and then the face was cleaned with damp face towel and dried. The baby's neck was supported and the ears were plugged with the thumb and middle finger to prevent water from entering the ears. The hair was washed with soap and sponge in a circular manner, rinsed, dried and covered with a cleaned cap.

The baby was put back on the working surface and exposed arms and front of the trunk was washed to the feet paying attention to the skin folds then turned and with one arm supporting the chest and the back was washed down to the feet paying attention to the skin folds. Baby's body was immersed in a bath of warmed water, with the head supported above the water and the body rinsed thoroughly. The baby was then placed on a cleaned cot sheet and a small clean dried towel was used to dry the body paying attention to the skin folds. Baby oil was applied on the skin and baby was dressed leaving the umbilical cord exposed for dressing and

the hair combed neatly. Gloved hands were dipped into 0.5 percent chlorine solution and were removed and discarded, hands were washed and dried with clean towel. Sterile gloves were then put on. Cord was inspected for bleeding and there was no bleeding. Sterile cotton wool swabs and methylated spirit was to dress the cord. One was used to hold the clamp and the cord was dressed aseptically with a cotton wool swab soaked in methylated spirit from the base upwards to the cord clamp and left it opened by dry gangrene. The baby was wrapped nicely to maintain temperature. The baby`s head was covered with a cap and dressed nicely to prevent heat loss and the baby was given to the mother to breastfeed in an effort to support breastfeeding. Mother was asked to fix baby to breast by ensuring that she sat in a comfortable position, which meant that the baby should be fed for at least eight to twelve times a day and exclusively for six months. Mother was educated on breastfeeding problems such as cracked or sore nipples, breast engorgement and mastitis. She was asked to report to the clinic especially if the problem was not resolved and also signs of engorgement were noticed.

4.3 FIRST DAY POST DELIVERY (DAY OF DISCHARGE)

The first day post-delivery for Madam Patricia was on the 21st December 2020. Client was asked about her sleep during the night and she said, she slept well but had to wake up intermittently to breastfeed her baby. Her vital signs were then checked and recorded as follows:

Temperature	36.3 degree Celsius
Pulse	84 beats per minute
Blood pressure	114/69mmHg
Respiration	21 cycles per minute

Permission was sought for head to toe examination to be performed on her and was granted, and there was no abnormality detected. The breast was lactating well and the uterus was well contracted when palpated and measured with symphysio fundal height of 16cm. On inspection of the perinea pad, the lochia flow was small and the colour was red (rubra) with no odour. She was encouraged to ambulate to promote effective circulation and drainage of lochia. She took her baby after she was served with warm porridge and a loaf of bread as breakfast. Baby was also examined with permission from the mother after hand washing was done with soap under running water and dried with clean towel. A thorough head to toe examination was performed on the baby again but no abnormality was detected.

The cord was inspected for bleeding, odour and discharge but there was none. The baby was top and tailed with the cord dressed with chlohexidine. The baby was dressed nicely and wrapped in clean warm sheet. The baby's weight was 2.8kilogram. The baby`s vital signs were checked and recorded as follows:

Temperature	36.9 degree Celsius
Pulse	120 beats per minute
Respiration	40cycles per minute

Education on how to position herself when breastfeeding and how to put the baby to breast were demonstrated to Madam Patricia to enable her breastfeed well and prevent breast sore.

She was asked to give return demonstration and she did that perfectly. She was informed that she would be discharged that day so the baby was reassessed to rule out any abnormality.

She was educated on the intake of nutritious diet which would help boost her immunity and repair worn out tissues. She was told to maintain good personal hygiene and also advised and encouraged to sleep whenever the baby is sleeping so that she can also have rest. She was educated on the minor disorder in puerperium such as breast engorgement and skin rashes on the baby and told to report to the clinic whenever she sees them.

The baby was given polio oral vaccine and bacilli culmette guerm (BCG) immunization before they were discharged home. Routine drugs were served as follows:

Tablet folic acid 5mg once daily for 7days.

Tablet multivitamin 200mg once daily for 7 days

Table ferrous sulphate200mg once daily for 7 days.

Madam Patricia was also advised on the importance of keeping the baby's cord clean and dry, to avoid the application of unprescribed medications on it. Madam Patricia was also educated on the importance of reporting to hospital anytime she notices danger signs like bleeding from the cord, offensive odour from the cord or high temperature of the baby. Madam Patricia was encouraged to sleep under treated mosquito net together with the baby to prevent malaria.

She was also educated to breastfeed the baby on demand and also encouraged her friend and mother to help her take care of the baby. Client was encouraged to have adequate rest and sleep. The information about visits to her house to continue the care up to the seventh day was reinforced and they were seen off at 2:00pm.

4.4FIRST POSTNATAL HOME VISIT

On the 21st December 2020 at 4:00pm, Madam Patricia was visited in her house at Jinijini. Greetings were exchanged and a warm welcome and seat was offered. She was asked about her health and that of her family and she responded that they are all well.

Permission was sought from Madam Patricia to examine her which she agreed. After hand washing was done with soap under running water and dried. On examination, the breasts were lactating well. The symphysio fundal height was measured as 16cm with uterus well contracted. The perinea pad was checked and the colour of the lochia was red with no foul smell and scanty in amount. Client complained of severe abdominal pains when the baby suckles. She was reassured and encouraged to perform postnatal exercises to strengthen the pelvic floor muscles and was encouraged to breastfeed the baby on demand, it help in contraction thus involution of the uterus. There were no observed abnormalities. Her vital signs were checked and recorded as follows:

Mother

Temperature	36.1 degrees celcius
Respiration	20 cycle per minute
Blood pressure	120/60 millimetres of mercury
Pulse	76 beat per minute
Breast	Lactating
Uterus	Contracted
SFH	16 cm
Lochia	Rubra

Again permission was sought from the mother to examine the baby which she agreed. The baby was examined from head to toe with no abnormality detected.

The baby`s vital signs were as follows:

Temperature	36.2 degrees celcius
Respiration	42 cycle per minute
Pulse	126 beat per minute
Suckling	Good
Cord	Clean and dry
Colour	Pink
Stool	Meconium

4.5 SECOND POSTNATAL HOME VISIT

On the 22nd December 2020 at 8:00am and 4:00pm, Madam Patricia was visited in her house at Jinijini. Greetings were exchanged and a warm welcome and seat was offered. She was asked about her health and that of her family and she responded that they are all well.

Permission was sought from Madam Patricia to examine her which she agreed. After hand washing was done with soap under running water and dried. Head to toe examination was carried out with no abnormality detected. The breasts were lactating well with symphysio fundal height measured as 14cm. The perinea pad was checked and the colour of the lochia was bright red with no foul smell and scanty in amount. There were no observed abnormalities. Her vital signs were checked and recorded as follows:

Mother	**Morning**	**Evening**
Temperature	36.2 degrees celcius	36.1 degree celcius
Respiration	18 cycle per minute	24 cycle per minutes
Blood pressure	120/62 millimetres of mercury	112/78 millimeters of mercury

Mother	**Morning**	**Evening**
Pulse	78 beat per minute	82 beat per minute
Breast	Lactating	Lactating
Uterus	Contracted	Contracted
SFH	14 cm	14 cm
Lochia	Rubra	Rubra

Again permission was sought from the mother to examine the baby which was agreed. The baby was examined from head to toe with no abnormality detected. The baby`s vital signs were as follows:

Baby	**Morning**	**Evening**
Respiration	40 cycle per minute	44 cycle per minute
Pulse	128 beat per minute	132 beats per minute
Temperature	36.4 degrees celcius	36.1 degree celcius
Weight	2.7kg	2.7kg
Suckling	Good	Good
Cord	Clean and dry	Dry and clean
Colour	Pink	Pink
Stool	Meconium	Meconium

The cord was dressed with methylated spirit. After that baby was dressed nicely, wrapped in a warm clean sheet and was given to the mother to breastfeed.

Madam Patricia was encouraged to continue the practice of exclusive breastfeeding not to put anything on the cord apart from the chlohexidine and also wash hands before handling baby.

Madam Patricia complained of fatigue and backache and she was encouraged to have enough rest during the day and also during the night. She was also told to use proper body mechanics when breastfeeding. She was thanked and permission to leave was sought.

4.6 THIRD POSTNATAL HOME VISIT

On the 23rd December 2020 at 8:00am, Madam Patricia was visited in her house. Greetings were exchanged and a warm welcome and seat was offered. She was asked about her health and that of her family and she responded that they are all well. Permission was sought from Madam Patricia to examine her which she agreed. After hand washing was done with soap under running water and dried. The breast were lactating well with symphysio fundal height measured as 12cm. The perinea pad was checked and the colour of the lochia was red with no foul smell and scanty in amount. There were no observed abnormalities. Her vital signs were checked and recorded as follows:

Mother	**Morning**	**Evening**
Temperature	36.4degrees Celsius	36.2 degree celcius
Respiration	22 cycle per minute	20 cycle per minute
Pulse	84 beat per minute	81 beat per minute
Blood pressure	108/70 millimetres of mercury	110/70 millimeters of mercury
Breast	Engorged	Engorged
Uterus	Contracted	Contracted
SFH	12 cm	12 cm
Lochia	Rubra	Rubra

Again permission was sought from the mother to examine the baby which was agreed. The baby was examined from head to toe. The baby`s vital signs are as follows:

Baby	**Morning**	**Evening**
Temperature	36.1 degree Celsius	36.2 degree celcius
Respiration	40cycle per minute	43 cycle per minute
Pulse	130 beat per minute	138 beat per minute
Weight	2.7kg	2.7kg
Suckling	Good	Good
Cord	Clean and dry	Dry and clean
Colour	Pink	Pink
Stool	Yellowish	Yellowish

The cord was dressed with chlohexidine. After that baby was dressed nicely, wrapped in a warm clean sheet and was given to the mother to breastfeed. Education was given on prevention of infection. Client complained of engorged breast which she was encouraged to feed the baby on demand and also apply warm compresses to it. Permission was sought to leave

4.7 FOURTH POSTNATAL HOME VISIT

On the 24th December 2020 at 8:00am, Madam Patricia's family was paid another visit. Warm greetings were exchanged and her health and that of the family was asked and she said they were fine. Purpose of the visit was made known to her. Permission sought for head to toe examination which was granted and no abnormalities detected. Her breasts were lactating well. Her perinea pad was inspected for lochia and the flow was small, pink in colour (serosa)

and was not offensive. Her symphysio fundal height measured was 10 cm. Her vital signs were checked and recorded as:

Mother	**Morning**
Temperature	36.3 degree Celsius
Pulse	80 beat per minute
Respiration	21 cycle per minute
Blood Pressure	108/70 millimetres of mercury
Mother	**Morning**
Breast	Lactating
Uterus	Contracted
SFH	10cm
Lochia	Serosa

The cord was dressed. It looked dry and about to slough off and the baby was nicely dressed and wrapped in a clean sheet and made comfortable in bed.

Baby's vital signs:

Baby	**Morning**
Temperature	36.6 degree Celsius
Pulse	131 beat per minute
Respiration	44 cycle per minute
Weight	2.8kg
Suckling	Good
Cord	Almost off
Colour	Pink
Stool	Yellowish

Client complained of sleep disturbances as a result of night feeding. She was reassured and educated on the various position to assume when breastfeeding. And she was informed of the next visit.

4.8 FIFTH POSTNATAL HOME VISIT

Client was visited on 25th December 2020 at 8:00am. On arrival, greetings were exchanged and she was asked about her health and that of the family and she responded that they were doing well. After the purpose of the visit was explained to Madam Patricia, her vital signs were checked and recorded as follows;

Mother	**Morning**
Temperature	36.2 degree Celsius
Pulse	76 beat per minute
Respiration	18 cycle per minute
Blood pressure	112/73millimeters of mercury
Breast	Lactating
Uterus	Contracted
SFH	8cm
Lochia	Serosa

Her perinea pad was inspected and the lochia was pink (serosa) with scanty flow and not offensive. Her symphysio fundal height was 8cm. The baby was top and tailed and the cord was dressed nicely. It looked very dry and it was reported that she passed yellowish stool. The baby was dressed and wrapped in a clean warm sheet and was given to the mother to

breastfeed. Client was reminded of the practice of good personal hygiene. Baby`s vital signs were checked and recorded as follows:

Baby	**Morning**
Temperature	36.7 degree Celsius
Pulse	120 beat per minute
Respiration	37 cycle per minute
Weight	2.9kg
Suckling	Good
Cord	Off
Colour	Pink
Stool	Yellowish

Madam Patricia was asked if there was any complain and she said there was none. She was thanked and permission was sought to leave.

4.9 SIXTH POSTNATAL HOME VISIT

On 26th December 2020, client and family were visited again at 8:00am.Greetings were exchange and client health was asked and she responded were doing well. Permission was then sought and daily routine examination was carried out on both mother and baby from head to toe and no abnormality was detected in any of them. Their condition was very good and both looked healthy. Lochia was inspected and the colour was creamy brown and scanty flow (Alba) with no foul odour. Symphysio fundal height was 6cm and vital signs checked and recorded as follows:

Mother	**Morning**
Temperature	36.3 degree Celsius
Pulse	80 beat per minute
Respiration	19 cycle per minute
Blood pressure	120/70 millimetres of mercury
Breast	Lactating
Uterus	Contracted
SFH	6 cm
Lochia	Alba

On examination of the baby, the cord was seen to have fallen off and a baby bath was provided and the mother was educated on how to properly bath the baby and avoid pouring hot water on the head and genital areas and also continue to keep the stump dry always and also not apply any herb. Baby`s vital signs were checked and recorded as follows:

Baby	
Temperature	36.5 degree Celsius
Pulse	124 beat per minute
Respiration	42 cycles per minute
Weight	3.0kg
Suckling	Good

Cord	Off
Stool	Yellowish

Madam Patricia was asked if there was any problem but she said there was none. She was reassured and her mother was also encouraged to help in taking care of the baby. She was thanked and permission was sought to leave.

4.10 SEVENTH POSTNATAL HOME VISIT

On 27th December 2020, client and family were visited again. A warmly greetings were exchanged and the health of client and her family was inquired and positive response was given. Permission was then sought and routine examination was carried out on both mother and baby from head to toe and no abnormality was detected in any of them. Mother was examined from head to toe and no abnormality was detected. Her perinea pad was inspected and lochia was scanty and pinkish in colour. The symphysio fundal height was 4cm. The baby`s bath was provided and stump was clean. The vital signs were checked and recorded as follows:

Mother

Temperature	36.1 degree Celsius
Pulse	75 beat per minute
Respiration	18 cycles per minute
Blood pressure	110/60 millimetres of mercury
Breast	Lactating
Uterus	Contracted

SFH	4cm
Lochia	Alba

Baby

Temperature	36.8 degree Celsius
Pulse	126 beat per minute
Respiration	38 cycle per minute
Weight	3.1kg
Suckling	Good
Cord	Off
Colour	Pink
Stool	Yellowish

Client was asked whether she had complaints that day but she had nothing to report. She was thanked and reminded of the last visit which would be the next day

4.11 FIRST POSTNATAL VISIT TO THE CLINIC

Madam Patricia and her baby reported to the clinic on 28th December 2020 for the 7 to 10 days postnatal examination. She was welcomed and offered a seat. She was asked how they were faring and she responded that they were doing well. Procedures to be carried on her and the baby were explained and she consented. Midstream urine was collected from her for protein and sugar and it was negative. Her haemoglobin was checked and recorded as 13.3g/dl. Her vital signs were checked and recorded as follows:

Temperature	36.2 degree Celsius

Pulse	76 beat per minute
Respiration	21 cycle per minute
Blood pressure	112/81 millimetres of mercury

Madam Patricia was assisted to undress and lie on the bed for head to toe examination. Hands were washed and dried with clean towel. On examination, her hair was nicely braided and neatly kept. The eyes were inspected for pallor and discharges, the nose and ears were also inspected for discharges but nothing abnormal was detected. There were no swellings or lymph nodes around the neck. The breast was lactating well and was educated on breastfeeding the baby on demand to avoid breast engorgement.

On abdominal examination, involution had taken place. The extremities were free from edema, equal in size and no abnormalities detected. On vulva inspection, the lochia had stopped flowing and the vulva was neatly kept with no odour. No abnormality was detected on the lower extremities too. She was assisted out of the bed and all finding communicated to her. The baby was also examined in the presence of Madam Patricia but no abnormality was detected. The baby`s weight was 3.2kg baby`s vital signs were checked and recorded as follows:

Temperature	36.3 degree Celsius
Pulse	142 beat per minute
Respiration	38 cycle per minute
Weight	3.2 kg

Findings on the baby were communicated to her and she was congratulated for taking good care of the baby and herself. She was educated on various family planning methods and the

benefits of practicing family planning, when to resume sex and the need to feed the baby exclusively for six months.

She was also educated on the need to attend child welfare clinic in order to monitor the growth of her baby, early detection of diseases to complete all the immunization. She was reminded of the importance of rest, eating nutritious diet, maintaining good personal hygiene, baby care, breastfeeding and breast care.

Finally, she was handed over to the midwife in charge for the continuity of care. She was congratulated and thanked for her cooperation and support.

4.12 SECOND POST-NATAL VISIT TO THE CLINIC

According to the midwife incharge, on the 29th January, 2021 client came to the clinic for six weeks visit. They were warmly welcome and they looked very healthy. General examination was conducted from head to toe as well as vital signs after her permission was sought. Her vital signs were checked and recorded as follows;

Temperature	36.4^{o}C
Pulse	78bpm
Respiration	20cpm
Blood pressure	110/70mmHg

Madam Patricia was given a urine sample container to provide midstream urine to be sent to the laboratory for urine analysis to be performed. A sample of blood was also taken to the laboratory for haemoglobin level estimation. The samples were then sent to the laboratory. The results from the laboratory were as follows;

Haemoglobin	12.2g/dl

Urine protein	Negative
Glucose	Negative

The results were explained to her and recorded in her card. Head to toe examination was done on her with no abnormalities detected. She had not resumed her menses when asked. She was educated on the need to start a family planning method to prevent unwanted pregnancy. All the family planning were explained to her and she preferred the lactational amenorrhea as a natural family planning method.

Her baby was also examined from head to toe and no abnormalities were detected. On the head, the anterior fontanelle was palpated for pulsation and it was normal. The posterior fontanelle had closed. Vital signs were checked and recorded as follows;

Temperature	36.2^{o}C
Respiration	34cpm
Apex heart beat	134bpm
Weight	4.8kg

Madam Patricia and her baby were handed over to the child welfare clinic and family planning unit for the six weeks immunization against diphtheria, pertussis, tetanus, haemophilus, influenza and hepatitis B.

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

4.13 CARE PLAN DURING PUERPERIUM

- 21/12/20 After pains.
- 22/12/20 Fatigue.
- 22/12/20 Backache.
- 23/12/20 Engorgement of breast.
- 24/12/20 Sleep disturbances.

Short Term Objectives

- Client will be relieved of after pains within 48 hours.
- Client will be relieved of fatigue within 24 hours.
- Client`s backache will reduce within 24 hours.
- Client`s breast engorgement will reduce within 24 hours.
- Client will at least have six hours of sleep within 24 hours.

Long Term Objectives

Client will go through puerperium successfully without any complication.

TABLE 1: THE NURSING CARE PLAN FOR MADAM PATRICIA

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS
21/12/20 8:00pm	After pains related to uterine contractions.	Client will be relieved of after pain within 48 hours as evidence by: 1.Client verbalizing that She is relieved of after pain. 2. Midwife visualizing that client is relieved of the after pain.	1. Reassure client that the pain is temporary 2. Educate client to gently massage the lower abdomen to help the uterus to contract 3. Educate the client to assume a comfortable position. 4. Encourage the client to empty her bladder frequently. 5. Serve prescribed analgesics.	1. Client was reassured that the pain is temporary. 2. Client applied a gentle massage a the lower abdomen which helped th uterus to contract. 3. Client was encouraged to assumed a prone position with pillow under her lower abdomen to exert Pressure which helped to relieve her from the pain. 4 .Client was encouraged to empty her bladder at least every two hours or whenever there is the urge. 5. Tab paracetamol 1 gram tidx3 was given.

TABLE 2: THE NURSING CARE PLAN FOR MADAM PATRICIA

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS
22/12/20 at 8:30am	Fatigue related to disturbed sleep pattern due to	Client will be relieve of fatigue within 24 hours as evidence by: 1. Client	1. Reassure client. 2. Encourage client to sleep in the day when baby is asleep. 3. Encourage family support.	1. Client was reassured that she would regain her energy. 2. Client slept in the day when the baby was asleep. 3.Client's mother was encouraged t

	physical demands of caring for the new born.	verbalizing that she is relieved of fatigue. 2. Midwife visualizing that client is relieved of fatigue.	4. Encourage client to have enough rest 5. Educate client to take nutritious diets.	assist in the caring of the baby 4. Client was encouraged to have at least two hours rest daily during the day and six hours at night. 5. Client was encouraged to take in diet containing all the food nutrients like carbohydrate and protein etc.

TABLE 3: THE NURSING CARE PLAN FOR MADAM PATRICIA

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS
23/12/20 at 8:30am	Backache related to poor feeding and sitting posture.	Client`s backache will reduce within 24 hours as evidenced by client verbalizing a reduction of pain.	1. Reassure client. 2. Explain the cause of backache to client. 3. Educate client on the proper use of body mechanicsand good posture. 4. Educate client to assume a correct position during breastfeeding. 5. Educate client not to bend down during household chores.	1. Client was reassured that pain will resolve. 2. The causes of backache were explained to client. 3. Client was educated on the prope use of body mechanics and good posturing. 4. Client was educated to be straigh with her back supported when feeding the baby. 5. Client was educated to bend from knees during household chores.

TABLE 4: THE NURSING CARE PLAN FOR MADAM PATRICIA

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS
23/12/20 at 4:30pm	Engorgement of breast related to poor feeding pattern.	Client`s breast engorgement will reduce within 24 hours as evidenced by client verbalizing that the pain has reduced.	1. Reassure client to allay anxiety. 2. Explain the cause of the engorgement of breast to client. 3. Encourage client to breastfeed on demand. 4. Assist client to position and fix baby to breast. 5. Ensure client empties one breast completely before offering another one.	1. Client was reassure to allay anxiety. 2. The cause of breast engorgement was explained to her. 3. Client was encouraged to breastfeed on demand. 4. Client was assisted to position and fix baby well to breast. 5. Complete empty of breast was ensured.

TABLE 5: THE NURSING CARE PLAN FOR MADAM PATRICIA

DATE/ TIME	NURSING DIAGNOSIS	OBJECTIIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTIONS
24/12/20 at 8:30 am	Sleep disturbance related to breastfeed of baby at night.	Client will have at least six hours of sleep within 24 hours as evidenced by 1.Client verbalizing that	1. Reassure client that her sleeping pattern will be restored to normal. 2. Encourage client to feed baby on demand. 3. Encourage client to ensure	1. Client was reassured that her sleeping pattern will improve. 2. Client was encouraged to breastfeed baby two hourly or eight to twelve times. 3. Client was encouraged to ensure

		she was able to sleep for about 8 hours in the night.	baby is always dry and comfortable. 4. Teach client how to breastfeed whilst lying. 5. Encourage family support.	baby is dry and comfortable by changing soiled napkins. 4. Client breastfed whilst lying on one side. 5. Client's mother was encouraged to help her in taking care of the baby.

SUMMARY AND CONCLUSION

The family centered maternity care study was conducted on Madam Baah Patricia, a 38 years old gravida 3 para 2alive and her entire family. Care was given during antenatal, labour and puerperium periods and these processes weregone through successfully.

Madam Patricia first visit to the clinic was on 20thDecember, 2020 when she was 8 weeks pregnant and attended the clinic till delivery and the first contact with her was on 26th December, 2020 when she was 36 weeks pregnant.

She had spontaneous vaginal delivery of a life female child on the 20th December, 2020 without any complications and went through a normal and safe puerperium. She and her family were cooperative, supportive and acted towards any form of education given to them. Through home visits, a close monitoring was made throughout puerperium and education given on how to care for herself and the baby and they were later handed over to the midwife in charged for continuity of care.

To conclude, this care study has given me the student midwife opportunity to put my theoretical knowledge into practice and has therefore boost the confidence level in me and has also help me to improve upon my ability in caring for other pregnant women whom I shall meet in the nearest future throughout pregnancy, labour and puerperium successfully.

I have learnt to care systematically for a pregnant woman and her family.

It has also broadened my knowledge on issues concerning pregnancy, labour and puerperium.

I have also learnt how to care for a pregnant women in her own environment.

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APPENDIX 1

ANTENATAL RECORDS

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
11/06/20	57kg	100/60mmHg	negative⁄ negative	8weeks	-	-	-	+	Routine drugs	No complains	Janet
9/07/20	58kg	110/70mmHg	negative⁄ negative	16weeks	15cm	-	-	+	Routine drugs	No complaints	Janet
6/08/20	59kg	100/70mmHg	negative⁄ negative	20 weeks	19cm	-	-	+	Routine drugs.	No Complaint	Janet
3/09/20	60kg	111/60mmHg	negative⁄ negative	24weeks	25cm	-	-	Present	Routine drugs.	No complains	Janet

DATE	WEIGHT (KG)	BLOOD PRESSURE	URINE FOR PROTEIN/ SUGAR	GESTATIONAL AGE IN WEEKS	FUNDAL HEIGHT (CM)	PRESENTA-TION	DESCENT OF FETAL HEAD	FETAL HEART RATE (FH)	TREATMENT GIVEN	COMPLAIN	SIGN
1/10/20	61kg	120/80MmHg	negative/ negative	28weeks	27cm	-	-	Present	Routine drugs	Heartburns	Janet
29/10/20	62kg	110/70mmHg	negative/ negative	32weeks	31cm	Cephalic	5/5th	130bpm	Routine Drugs	No complaint	Janet
12/11/20	63kg	130/90mmHg	negative/ negative	34weeks	33cm	Cephalic	5/5th	138bpm	Routine Drugs	No complains	Janet
26/11/20	64kg	110/70mmHg	negative/ negative	36weeks	35cm	Cephalic	5/5th	138bpm	Routine Drugs	No complains	
3/12/20	65kg	120/80mmHg	negative/ negative	37weeks	36cm	Cephalic	5/5th	138bpm	Routine Drugs	Frequency of micturition	

10/12/20	66kg	100/70mmHg	Negative/negative	38weeks	37	Cephalic	5/5th	138bpm	Routine Drugs	No complain	
17/12/20	67	110/70mmHg	Negative/negative	39weeks	38	Cephalic	5/5th	140bpm	Routine Drugs	Backache	Sandra

LLIN Given – 22/02/2018

TETANUS IMMUNIZATION	PREVIOUS TT		TD 1 Yes TD 2 YES		TD3 YES	
	CURRENT TT		TD 4 Date		TD 5 Date	
			11/6/20		9/7/20	
INTERMITTENT PREVENTIVE TREATMENT (IPT)FOR Malaria	1ST dose SP* 3 tabs (Directly Observed Therapy) 6/08/20	Gestation age In weeks	2nd dose (1 month after 1st dose (Directly Observed Therapy) 3/09/20	Gestation age In weeks	3rd dose (1 month after 2nd dose (Directly Observed Therapy)1/10/20	Gestational age in weeks
		20weeks		24weeks		28weeks

FOURTH DOSE	29/10/20	32weeks
FIFTH DOSE	26/11/20	36weeks

APPENDIX II

LABORATORY INVESTIGATION

DATE	**SPECIMEN**	**IVESTIGATION TYPE**	**FINDINGS**	**REMARKS**
11/06/20	Blood	Groupings	B	Normal
		Rhesus factor	Positive	Normal
		Haemoglobin level (HB)	12.2g/dl	Normal
		Hepatitis B (HBsAg)	Negative	Normal
		Sickling	Negative	Normal
		VDRL	Non-reactive	Normal
		Glucose 6 phosphate	No defect	Normal

		dehydrogenase(G6PD) HIV Status	 Negative	 Normal
11/06/20	Urine	Protein	Negative	Normal
		Glucose	Negative	Normal
	Stool	Worm infestation	Negative	Normal
9/07/20	Urine	Protein/Glucose	Negative/negative	Normal
6/08/20	Urine Urine	Protein/Glucose Protein/Glucose	Negative/negative Negative/negative	Normal Normal
1/10/20	Urine	Protein/Glucose	Negative/negative	Normal
29/10/20	Blood	Haemoglobin (HB)	12.6g/dl	Normal
		Hepatitis B (HBsAg)	Non-reactive	Normal
		PMTCT	Non-reactive	Normal

	Urine	Protein/Glucose	Negative/negative	Normal
12/11/20	Blood	Haemoglobin level	12.2g/dl	Normal
	Urine	Protein/Glucose	Negative/negative	Normal
26/11/20	Blood	Haemoglobin level	11.4g/dl	Low
	Urine	Protein/Glucose	Negative/negative	Normal

Appendix III

PHARMACOLOGY OF DRUGS (MOTHER)

Drugs	**Classification**	**Dosage**	**Route**	**Actions and Uses**	**Actual Effect**	**Side Effect**	**Side Effects Experienced**
Ferrous Tablet	Haematinics	200mg daily	Orally	Aids in Red Blood Cell formation	Increase in hemoglobin level	Black stool, diarrhea and constipation	None observed
Folic Acid Tablet	Vitamin preparation	5mg daily	Orally	Helps in the formation of blood cell	Increase in hemoglobin level	Nausea, vomiting, diarrhea and constipation	None observed
Multivitamin Tablet	Vitamin preparation	200mg daily	Orally	Increases appetite and helps in the formation of Red Blood Cells	Increase in appetite	Gastrointestinal disturbance	None observed

Paracetamol Tablet	Antipyretics/ Analgesic	1g tds x 3	Orally	Reduces mild to moderate pain	Client pain was relieved	Liver damage due to prolong use	None observed
Tetanus Injection	Anti-tetanus drugs	0.5mg	Intra-muscular	Protect mother and fetus against infections	Client was protected against tetanus infection	Nausea, general ill feeling	None observed
Metronidazole tablet	Anti-infective	400mg tds x 30	orally	Prevention of infection	Infection was prevented.	Dizziness, headache,nausea,	None observed
Sulfadoxinepyramethamine Tablet	Anti-malaria prophylaxis	3 start 16 weeks after quickening	Orally	Prevention of malaria	Malaria was prevented	Urticaria rash, dizziness, nausea, stomatitis	None observed

		and other 2 doses 4.					
Oxytocin injection	Oxytocin drug	10 units	Intra-muscular	Increase uterine contraction and control bleeding	Client had good uterine contraction	Vomiting, uterine spasm and raised blood pressure	None observed
Vitamin A capsule	Group A vitamin supplement	200,000 units for 2 days	Orally	Growth development and proper vision	Normal vision and healthy skin	Vomiting	None observed

PHARMACOLOGY OF DRUGS (BABY)

Drugs	**Classification**	**Dosage**	**Route**	**Actions and Uses**	**Actual Effect**	**Side Effect**	**Side Effects Experienced**
Vitamin K	Group K vitamin	1.0mg	Intra-muscular	Prevent haemolytic diseases	No bleeding	Risk of haemolysis in people with G6PD, rashes and brain damage	None observed
Genta-Mycin	Antibiotics	2 drops	Instillation	Prevent eye infection	Increase risk of a plastic anemia	totoxicity and nephrotoxicity	None observed
Bacillus calmett Guerin injection	Antigen	0.5mg	Intra-dermal	Immunity against tuberculosis	Under observation	Mild fever, swelling of injection site and blister formation	Blister noticed
Polio O	Antigen	2 drops	Orally	Production of antibodies to prevent poliomyelitis	Under observation	There may be diarrhea	None observed

Hepatitis B vaccines	Antigen	0.5ml	Subcutaneous	Immunity against hepatitis B virus	Under observation	Fever	None observed
Diphtheria portussis tetanus	Antigen	0.5ml	Subcutaneous	Immunity against Diphtheria pertusis tetanus	Under observation	Fever	None observed
Haemophilus influenza Hepatitis B	Antigen	0.5ml	Subcutaneous	Immunity against Haemophilus influenza Hepatitis B	Under observation	Fever	None observed

SIGNATORIES

NAME:BOAKYWEAA SANDRA

(STUDENT MIDWIFE)

SIGNATURE: …….

DATE: **……**

NAME:MADAM NTIWAA AGNES

(MIDWIFE IN-CHARGE)

SIGNATURE: ……

DATE:…….

NAME: MADAM AMINA YAKUBU

(SUPERVISOR)

SIGNATURE:……..

DATE:……

NAME: MS MONICA NKRUMAH

(PRINCIPAL)

SIGNATURE:…….

DATE:**……**