NURSING AND MIDWIFERY TRAINING COLLEGE,

KETE-KRACHI

A FAMILY CENTERED MATERNITY CARE STUDY

WRITTEN

ON

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BY

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PREFACE

A family centered maternity care study is an approach of nursing a pregnant woman and her family as a whole within a period of time. It includes antenatal, labour, puerperal care and management in order to meet the client's physical, psychological, socio economic and spiritual needs.

The whole concept includes the use of the nursing process with scientific approach of collecting data, observation, analyzing, planning, implementing and evaluating of nursing care rendered by the student midwife to the client. It allows the student midwife to choose a client and render care to her and her family in preparation and acceptance of the new member of the family. It helps the student midwife to build self-confidence and gain experience to offer effective care to a client.

It also forms part of the assessment by the Nursing and Midwifery Council of Ghana before awarding a diploma to practice as a midwife. The family centered maternity care study is compiled into a document in fulfilment for the award of the diploma in midwifery by the nursing and midwifery training council of Ghana.

For confidentiality, my client will be referred to as madam A.R/ throughout the writing of my family centered maternity care study

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I acknowledge with thanks the timely guidance and contribution which I received from the staff of the Antenatal unit and Maternity ward of Ketu South Municipal Hospital towards the writing of this care study. Not forgetting the matron and staff for your warm reception, support and ideas in choosing a client and writing family centered maternity care in my understanding and knowledge to compile this care study.

I also acknowledge my husband, Mr Adam Attachie,Eve Attachie and the entire family for their support in terms of prayers and finances to make this care study a success. God bless your endeavors. To all I couldn't mention I am grateful to you all.

Finally, I want to thank all the authors whose books I used as a reference point in making this a success.

I say, God richly bless you all.

INTRODUCTION

The family centered maternity care study is a systematic or comprehensive obstetric care rendered to an expectant mother, her family and her community members based on the clear understanding of the client as a unique individual with special needs and peculiar problems. The expectation and joy of every pregnant woman and a midwife is to deliver a healthy baby at term without injury, be it minor or major to both the mother and the baby.

This care study is about Madam A.R a 28 year old expectant mother gravida 2 para 1 at Ketu South Municipal Hospital I met my client on 26th November, 2020 at 36 weeks gestation during one of her visit to antenatal clinic and rendered total obstetric care.

My interaction lasted for 31 days (26Nov. to 27th Dec. 2020. At the beginning of my interaction, Madam A.R reported with some minor disorders in pregnancy including lower abdominal pain and frequency of micturition. She was reassured, educated on the cause and managements. At the end of the interaction thus 27th, December 2020 Madam A. R's minor disorders were solved. The condition of Madam A.R and her baby from the beginning to the end of the care was satisfactory.

This care study consist of four chapters namely; chapter one, chapter two, chapter three and chapter four.

Chapter one contains client particulars,her personal and social history,habit of daily living,family history, medical and surgical histories, menstrual history, past obstetric history and present obstetric history

.chapter two talks about antenatal home visit,subsequent ante natal clinic visit patient concept of pregnancy/child bearing,application of family centered care during pregnancy

Chapter three talks about admission, history taking, initial examination, nursing care and management rendered during the various stages of labour.

Chapter four talks about care given to mother and baby during 4th stage subsequent care of the baby, first day post-delivery, subsequent post-delivery home visits, first post-natal review, and nursing care plan during puerperium.

Lastly, termination of care, summary and conclusion, various appendices, pharmacology of drugs, bibliography and various signatories.

LITERATURE REVIEW

A literature review is a summary of a subject field that supports the identification of specific research questions. (Rowley & Slack, 2014). It involves a critical analysis of published sources on a particular topic. It provides a summary, classification, comparison and evaluation.

This literature review summarizes various works on pregnancy and how it affects the various body systems, labour and its stages and puerperium.

PREGNANCY

According to Perry (2000), pregnancy is defined as a process where living fertilized ovum is embedded in the uterus till labour starts and it lasts for 280days or 37 completed weeks to 42 weeks. Fraser & Cooper (2009), further described pregnancy as the fertilization of the ovum by the sperm after which the zygote travels using 3-4 days to get into the prepared uterus which allows for implantation to occur about the 8^{th} day of fertilization.

Women who are aware of their bodies might begin to suspect that they are pregnant within the first few days of pregnancy but for most, the first sign is missing a period. Other symptoms include nausea and vomiting, breast tenderness and fullness, urinary frequency and fatigue. (Marshall & Raynor, 2014).

The signs and symptoms that help in the diagnosis of pregnancy are divided into three. Presumptive, probable, and positive signs. Presumptive signs are the physiological changes experienced by the woman for her to think or assume she is pregnant. Examples include amenorrhoea, morning sickness, breast enlargement, bladder irritability and quickening. Presence of Human Chorionic Gonadotrophic Hormone in the blood or urine, abdominal enlargement, ballottement of foetus, changes in skin pigmentation, Jacquemier's, Heger's, and Osiander's signs are example of probable signs. The positive signs are visualization of foetus and gestational sac by ultrasound, hearing of

foetal heart sound by foetal stethoscope and Doppler, foetal movements and foetal parts palpable (Marshall & Raynor, 2014).

Researchers have agreed that, pregnancy is divided into three classical trimesters which are; first, second and third trimesters (Hare & Greenway, 2000; Fraser & Cooper, 2009). Each trimester has peculiar anatomical, physiological and biochemical changes that affect not only the reproductive system but also every system of the body. These changes explain the signs and symptoms of pregnancy and the many disorders that the client may complain about.

The first trimester begins from the day of conception through to the twelfth (12^{th}) week of pregnancy. It is also the period of adjustment for the pregnant woman to the fact that she is pregnant. The second trimester last between the 13^{th} and 26^{th} weeks of gestation. Most of the minor disorders such as early morning sickness and vomiting subsides during this trimester. The third and final trimester continuous from the 27^{th} week through to the commencement of labour usually 37 to 42 completed weeks (Abman, 2011).

Psychologically, Marshall & Raynor (2014), have found that women go through normal emotional changes during pregnancy and these changes are peculiar to each trimester. The first trimester is characterized by pleasure and excitement, disappointment, episodes of weepiness and increased femininity. A feeling of wellbeing, a sense of increased attachment to the foetus, increased demand for knowledge and information become prominent in the second trimester whereas loss of or increased libido, altered body image, anxiety about labour, anxiety about foetal abnormality etc. are experienced during the third trimester.

Physiologically, there are prominent changes in the reproductive system, the digestive system, genitourinary system, cardiovascular system, nervous system, endocrine system, respiratory system and musculoskeletal system and these changes cause most of the discomforts that pregnant women complain about (Mote, 2010). The uterus, which is the vital organ during pregnancy enlarges

gradually to accommodate the growing foetus and the placenta. The uterus rises out of the pelvis cavity as it enlarges to become an abdominal organ carrying the adjoining parts with them. As the cavity of the uterus fills with the growing foetus the uterus becomes globular and straight in shape instead of its original ante-verted and ante-flexed pear shaped.

The cervix also softens as a result of the hormone relaxin and looks purplish in colour due to increased blood supply. It however remains firmly closed as its canal is filled with operculum or mucous to prevent the entry of bacteria into the uterus. The vagina and its lumen also enlarges slightly (Fraser & Cooper, 2009). There is also an increase in vaginal secretion (leucorrhoea) and its acidity. Blood supply to the vagina increases as the vaginal wall becomes distended and blue in colour (Chadwick's/Jacquemier's sign). There is prickling and tingling sensation in the breast due to increase blood supply particularly around the nipple. Also, there is fullness in the breast, pigmentation of the areola and colostrum may leak from the breast in late pregnancy.

Changes in the digestive system include; nausea, vomiting, heartburns, ptylism and constipation. Nausea and vomiting is due to an increase in progesterone, oestrogen and human chorionic gonadotropins hormones, whilst heartburn occurs as a result of the displacement of the stomach upwards by the growing uterus leading to increase intragastric pressure and in turn oesophageal reflux. Also, ptyalism could be due to hormonal changes and constipation occurs as a result of displacement of the intestine and increase in production of progesterone which causes relaxation in the intestinal muscle, thereby decreasing peristalsis, which results in much water being absorbed from the faeces in the large intestine and hence causing constipation (Fraser & Cooper, 2009).

As pregnancy progresses to its final stages, there is pressure on the bladder by the growing gravid uterus causing frequency of micturition. Changes in the cardiovascular system includes vasodilatation during early pregnancy which is caused by the release of progesterone hormone. This may cause reduced blood flow to the brain leading to fainting or syncope. In late pregnancy, the

pressure on the inferior vena cava by the gravid uterus when the woman lies in a supine position for long may cause supine hypotensive syndrome (Fraser & Cooper, 2009).

The nervous system also brings about insomnia as a result of frequency of nocturnal micturition, discomfort when sleeping due to big abdomen, anxiety and hormonal changes.

In addition, the respiratory system changes to bring about dyspnoea and hyperventilation resulting from the overcompensation to the respiratory demand. The changes that take place in the musculoskeletal system include, backache which occurs as a result of increase in progesterone production thereby causing relaxation on the ligament and also, alteration in the balance of the body by the weight of the uterus (Holmes & Baker, 2006). Muscle cramps also occur and may be due to inadequate blood supply to a body part. There is also the presence of chloasma (a deep patchy colouration) on the face and linea nigra which is a pigmented line that runs from the umbilicus to some centimetres above the pubic bone. The stretching of the abdominal skin by the increasing size of the uterus causes stretch marks (straie gravidarum).

These changes are termed minor disorders in pregnancy and resolves spontaneously after delivery (Fraser & Cooper, 2009). They should therefore not be regarded as a burden on the mother's health but a temporal adaptation to changes during pregnancy.

LABOUR

Labor as defined by Marshall & Raynor (2014) as a process whereby with time, regular uterine contractions cause progressive effacement and dilation of the cervix, resulting in delivery of the fetus and expulsion of the placenta and membranes.

The World Health Organization (WHO 1999), defines normal labour as the kind with low risk throughout, spontaneous in onset with the foetus presenting by the vertex, culminating in the mother and baby in good condition following birth.

Labour is marked with the following signs and symptoms. The presence of painful rhythmic regular contractions, formation of fore waters, cervical effacement and progressive dilation of the cervix, the presence of show (bloody-stained mucous discharge from the cervix), and spontaneous rupture of membranes (Marshall & Raynor, 2014).

There are four stages of labour. The first stage is where there is rhythmic contraction and the cervix begins to dilate till it is fully dilated (10cm). In primigravidae the duration is expected to be from 8-12 hours while from 6-8 hours in multigravida. The first stage is divided into two phases; the latent phase where the cervix dilates from 0cm to 4cm and the active phase beginning from 4cm to 10cm.

The second stage is the expulsion of the foetus. It begins from the full dilatation of the cervix and completed when the baby is expelled or delivered. The time duration expected in primigravidae is 1 hour and in multigravida is 30 minutes. The third stage of labour is the separation and expulsion of the placenta and membranes and the control of bleeding. It begins from the delivery of the baby and completed when the placenta and membranes are expelled. The average duration expected from this stage is 30 minutes. The fourth stage is considered to be the first 6 hours immediately following childbirth where both mother and baby are thoroughly examined.

PEURPERIUM

Buckley (2006), defined puerperium as the period following the expulsion of the placenta and its membranes and thereby the mother enters a period of both physical and psychology recuperation. It can also be defined as the period starting immediately after delivery of the placenta and membranes and continues for 6 weeks (Fraser & Cooper, 2009). During this period, the uterus and other structures return to their pre-pregnant state (Fraser & Cooper, 2009) and the woman recovers

from the hassle of pregnancy, labour and delivery. The uterus shrinks back to its normal size and resumes its pre-pregnant position by the sixth week (Sira, 2010). This process is called involution. The breasts begins lactation. Colostrum, a high-protein form of milk, is produced immediately after birth and is gradually converted to normal breast milk, which has less protein and more fat by the fourth to seventh day.

During puerperium, there are discharges that comes from the uterus through the vagina. These discharges are termed lochia. Lochia consists of blood from the placental site, shreds of decidua, shed vaginal epithelial cells, and debris from the uterus. The odour of lochia is heavy but not offensive. Offensive lochia suggests infection. As involution progresses, the lochia undergo orderly changes. Lochia rubra is the first and lasts for about 4 days after delivery. It is red in colour. The second is lochia serosa, which is pink in colour and seen from about 5-9 days after delivery. The last to be noticed from about 9-14days is cream brown in colour and is called lochia alba (Akowuah, 2009).

Common disorders present in the puerperium include; after pain which is caused by involution of the uterus, frequent micturition and other urinary tract disorders, breast engorgement and constipation. Education to the mother and family members include exclusive breastfeeding on demand, good personal hygiene and perineal hygiene, taking of well nourishing diet and postnatal exercises. The family members are also encouraged to help the mother during this period by assisting the woman to do her house chores and also help to take care of the baby and mother.

During this period also, the newborn is immunized against some communicable diseases such as measles, rubella, yellow fever, hepatitis B, tuberculosis etc. and its growth is also monitored

WHY I CHOOSE MY CLIENT

Madam A.R.was chosen as a client for this care study because she met the criteria for the family centered care study by not having any major complication during her previous pregnancy,labour and peurperium as well as she is open and eager to more about her conditons in order to have a healthy pregnancy,she is regular attendant ante natal clinic of the Ketu South Municipal Hospital Aflao.where I met her on 26 November,2020 .

A flip through her folder revealed that she had a low HB level during previous pregnancy,so I decided to her as my client to educate her on some groups of food she should eat to enhance a very good HB.She then complain of lower abdominal pain, I then used this opportunity to persuade her to allow me use her for my care study and help with her problem

I introduced myself as sudent from Kete-Krachi Nursing and Midwifery College and would be grateful if she allow me to take as a client for my care study.She readily accepted and we exchanged phone numbers

CHAPTER ONE

ASSESSMENT OF CLIENT

This chapter elaborates the various types of assessment of the clients. Assessment is the deliberate and systematic collection of data to determine a patient's current, past and functional health status to determine the patient's present and past coping patterns. It also talk about assessment of Madam A.R. and her family .Her personal and social history habit of daily living ,psycho-social and physical home environment ,medical , surgical ,family and menstrual history, past and present obstetric history were also assessed.

PERSONAL AND SOCIAL HISTORY

Madam A.R. a 28years old pregnant woman.She stays at Aflao in Volta region with her family but she comes from Anyako as well as the husband too. She is fair in complexion and 157 centimeters tall and weigh 70kg She is a seamstress. Her level of is primary 6. Languages spoken include Ewe . She is married to Mr. E.N a driver and stays in the same house with her husband and their 5years old baby girl They are all Christians and worship at Christ the same Aflao. Her hobbies are watching movies and playing ludo. My client's favorite food is akple and palmnut soup with fish. She eats any other food and do not take alcohol neither does she smoke. Her next of kin is the husband who support her financially.

HABITS OF DAILY LIVING

According to Madam A.R is a seamstress .According to her she sleeps at 8:30pm and wakes up at 5:30am in the morning. She has her morning devotion with her husband which last 15minutes then washes her face, sweeps the compound, and washes her dirty linen and other household chores

She said; she prepares breakfast in the morning while the husband bath and dress the girl. Madam A.R. takes her bath twice daily and empties her bowel twice daily. She uses both pepsodent with

brush and also chewing stick for her oral hygiene which is done twice daily. At about 7:30am she and the husband depart for work. She eat three or four times day. She alleged that due to the pregnancy, she stopped working and is home with the mother in law but will resume after delivery. At her leisure time she listen to ewe songs and chat with her mother. She neither smokes nor take in alcohol. On Sundays she goes to church at 9am.She bathes 2or3 times a day depending on the weather and empties her bladder as soon as she feels the urge to pass urine.

MEDICAL HISTORY

Madam A.R has no hereditary condition like diabetes, hypertension, sickle cell, no communicable diseases like tuberculosis and no other chronic diseases like heart, jaundice, epilepsy, mental and respiratory disease. No sexually transmitted disease. She has no allergy for food and drugs.

SURGICAL HISTORY

Madam A.R said she had never undergone surgical operation or any injury affecting the reproductive system, no accident and never undergone any blood transfusion.

FAMILY HISTORY

Madam A.R. is the fifth born out of six children of the mother. She said there is no hereditary disease like Hypertension, diabetes, epilepsy, asthma, sickle cell, no known allergy, mental illness or any congenital malformations in the family. There is history of multiple pregnancies.

MENSTRUAL HISTORY

Madam A.R started her menarche at the age of 15 years and the flow is moderate and regular. She bleeds for 3days in each cycle. She has a cycle of 28days.she sometimes experiences lower abdominal pains of which she manages it with paracetamol tablet. She normally resumes her menses six month after delivery.

PAST OBSTETRIC HISTORY

Madam A.R. Gravida 2 para 1^{A},delivered her first child in 2015 with no history of abortion, stillbirth and preterm delivery. Rapport was established and procedure was explained to my client. I ensure she was comfortable and privacy provided. I ask about the previous pregnancy and the outcome. According to client no complications like antepartum haemorrhage (A.P.H), anaemia, severe malaria, hypertension, and jaundice during her pregnancy. I ask for interval between pregnancy and any ill health of which she said no but only some minor disorders of pregnancy like vomiting, nausea, heart burns, and loss of appetite, which was managed at Ketu South Municipal Hospital Aflao. She was regular attendant of Antenatal clinic at Ketu South Municipal Hospital Aflao

She took three doses of tetanus toxoid (T1, immunization and four doses of sulphadoxine pyrimethamine (S.P) as intermittent preventive treatment of malaria. She delivered her baby per vaginum at KSMH Aflao on the 11th March 2015. The baby is a female she weighed 3.2kg, baby cried soon after birth Madam A.R. said she attended the postnatal clinic and completed all immunization schedule such as BCG, Polio O and vaccine preventable disease as schedule for the child. No episiotomy nor complications like postpartum haemorrhage (PPH) or perineal tear. According to her, the placenta and its membranes were expelled few minutes after her delivery. Blood loss was 110mls.

She practice exclusive breastfeeding for six months and introduced complementary food such as porridge. She said her lochia was moderate for the first four days postpartum without any offensive smell. and was supported by the mother with care of the baby. Baby is alive and was doing well.

PRESENST OBSTETRIC HISTORY

Madam A.R, Gravida 2, para 1, first visited the antenatal clinic on the 7th May 2020. She could not remember her last menstrual period, but ultrasound scan reveals her EDD to be 19 December,2020 She is a regular attendant at Ketu South Municipal Hospital Aflao. She started her antenatal care visit on the 7th May, 2020 and it was recorded in the maternal health records booklet. She was 8 weeks pregnant by then. She complained of general body weakness. Her base line vitals were checked and recorded as;

Blood pressure	110/70 (mmHg)
Temperature	36.5ºC
Pulse	80 bpm
Respiration	20 cpm

Other observations made on weight and height record as;

Weight	69 kg
Height	157cm

Laboratory investigations, urine and the protein tested results are recorded as follows;

Sickling	Negative
Blood group	B positive
Rhesus	Positive (+)
Venereal Disease Research Laboratory	Negative
HIV/AIDS	Negative

G6PD	No defect
Haemoglobin level	11.5 gram per deciliter (g/dl)
HBSAG	Negative
Blood films for malaria parasite	Negative
Stool routine examination	No abnormality detected
Urine routine examination	No abnormality detected.

She carried out all her laboratory investigation and no abnormalities were detected. She attended the clinic regular till. I met her on the 26th November, 2020. Sulphadoxine pyrimethamine (SP) as prophylaxis for malaria and tetanus diphtheria was given on the 7th July, 2020 at 16 weeks of gestation, She took her second dose of sulphadoxine pyrimethamine on 19th August, 2020 , third dose on 19th October 2020, fourth dose on 27 May, 2020 and fifth dose on 11November,2020, as intermittent preventive treatment on malaria.

She was given the following routine drug;

Tablet fersolate	200mg daily for 30 days
Tablet folic acid	5mg daily for 30 days
Tablet multivitamin	200mg daily for 30 days

PSYCHOSOCIAL HOME ENVIRONMENT

My client lives in a house of 3 rooms with the husband, mother in-law and her child. The relationship was very cordial per the interaction I had with them.

PHYSICAL HOME ENVIRONMENT

Madam A.R lives in a house which was built with block and covered with iron sheets. The house is of 3 rooms, not painted, 2 windows on each room and roofed with aluminium roofing sheet. With permission obtained from my client I entered their bedroom which is neatly dressed, curtains were used, carpet on the floor, and other things in the room were well arrange. Their source of water is a well, area of refuse is a pit dug at the back of the house and is burnt every three days. I encouraged her to always make sure the place and house is always neat to prevent infections and to help maintain good health.

VALIDATION OF THE DATA COLLECTED

The data gathered was a true reflection of all information gathered from Madam A.R. and husband as well as patient medical records. The data was carefully and immediately recorded to avoid forgetting relevant information. No error was detected when data was cross checked with Madam A.R's maternal health record and standard literature of family centered maternity care study. Hence the data is deemed valid.

CHAPTER TWO

ANTENATAL CARE

This chapter narrates the care that was rendered to Madam A.R. during the ante natal period .It also entails report of client subsequent routine visit to ante natal clinic as well as home visits made and problems identified and how they were managed using nursing care.

FIRST INTERACTION WITH THE CLIENT

My first contact with Madam A.R. was on 26th November, 2020 at Ketu south Municipal Hospital Aflao at 10:00am when she was 36 weeks pregnant and that was her 7^{th} visit. I glanced through her Maternal Health Records book and I realized she was regular antenatal attendant; she has good past obstetric history and also meet the criteria to be chosen as a client for the family centered maternity care study. I also realized that from her previous pregnancy she had anemia. This prompted my intention to use her as my client.

I introduced myself to her as a student from Nursing and Midwifery College Kete-Krachi and I further introduced my intensions to her and we exchanged contacts after she accepted to be my client. She was weighed and recorded as 79kg.

I discussed with her the activities at the clinic and explained to her the procedures for the various examinations and privacy was provided. With permission, vital signs and observations were taken and recorded as follows;

Temperature	36.5^0C
Pulse	80 bpm
Respiration	20cpm

Blood pressure	100/60mmHg

Laboratory investigation

Haemoglobin level	12.0g/dl
Venereal Disease Research Laboratory (VDRL)	Non- reactive
Urine Routine Examination	No abnormality
HIV test	Non- reactive

I explained procedure to her and seek her consent and she agreed. She had already emptied her bladder so I provided privacy and helped her to undress. I helped her unto the examination couch, washed and dried my hands and proceeded with my examination under the supervision of a senior midwife.

On inspection, I realized her hair was free from infections, lice, dandruff and was neatly plaited. On the face, there was no puffiness of the eyelids, conjunctiva has no pallor and the sclera also had no yellowish discoloration. Her nose was centrally situated and there were no discharges, her lips were not cracked, her teeth was clean and light yellow with no bleeding gum or dental carries, her tongue was pink and there was no foul smell from the mouth, the ear was examined and found out to be normal, had no discharges and the pinnae of the ear was in alignment with the outer cantus of the eye. The neck and axillae were palpated for swollen lymph nodes, enlarged thyroid gland but none was detected Breast examination was done and no abnormality was detected, self breast examination was taught in the process. The areola was gentle squeezed for any abnormal secretion but none was present .Client was encouraged to practice the self breast examination taught especially the first three days after the menstrual period when she delivers and report any

abnormality found. Client upper limbs were found to be equal in length. The hands were checked for capillary refill time, shape and size which were normal, nails were trimmed and kept clean.

Abdominal examination was performed, the abdomen was exposed and inspected for scars, size and shape which is globular as well as signs of pregnancy, for example linea nigra, stiae gravidarium and fetal movement which were present .I warmed my hands and measured the symphysio-fundal height which measured 36cm.

During fundal palpation, I placed my hands on either side of the fundus, curved my fingers around it to determine what was contained in there and the buttocks were found. The lie was longitudinal during lateral palpation.

I used my palm to support one part of the abdomen and used the other palm to palpate the other side and vice versa and the fetal back was located at the left side of mothers abdomen indicating the position is left occiputoanterior.

Pelvic examination was done. I turned and faced the womans leg and asked her to flex her knees and breathe out slowly in a relaxed manner. I then placed my palms on either side of the uterus with the palm just below the level of the umbilical and fingers directing towards the symphysis pubis, thumbs almost meeting and the fetal head was felt indicating cephalic presentation. Descent was assesed for and was $5/5^{th}$ above the pelvic brim.

Auscultation for fetal heart rate was done. The fetoscope was warmed and placed below the place where the fetal back was located with my ears on it to listen to the heart rate and at the same feeling the maternal pulse to make sure that was not what I was listening to. The difference was clear in that the fetal rate was faster. I counted for a minute which read 143bpm with regular rhythm and volume.

The limbs were inspected for size, shape, length, varicose veins, edema and no abnormality was detected. I pleaded her to turn on her side so her back face me and two fingers were rubbed through her spine to detect any scoliosis or spina bifida but there was none. No sacral edema was also found.

Vulva examination was done and no abnormality was detected. I asked my client to lie on her left while I washed my hands help her to dress up and I therefore communicated the After the examination, Madam A.R. complained lower abdominal pain and loss of appitite, she was advised to at least try and eat twice daily, I also advised her to eat nutritious food to help with her growth and development as well as the fetus, She was encouraged to take in more fluids especially water to flush the urinary system of any waste product. I educated her on the various danger signs of pregnancy thus; excessive vomiting, oedema, bleeding per vagina etc. also to maintain personal hygiene and have enough rest thus sleep at least two hours during the day and six hours at night. She was given analgesics and routine drugs as follows:

Tablet folic acid	5mg daily for 30 days
Tablet multivitamin	200mg tds for 30 days
Tablet fersolate	200mg tds for 30 days

After the education, I introduced myself again and made my intention known to her and also introduced her to the midwife in-charge who also approved of her. She then gave me the directions to her house and we exchange contact. I therefore promise to visit her with a smile and also made it known to her that she can report to clinic any time she has a problem. I thanked her and saw her off.

FIRST ANTENATAL HOME VISIT

I visited my client on 26/11/2020 at 4:30pm as scheduled. The aim for this visit is to assess my client and the family as well as their environment. I met my client, her daughter and her husband at home. I was warmly welcomed and offered a seat with a sachet of water. We then exchanged greetings, which she introduced me to her family and they were pleased to see me. I asked of their wellbeing and they told me they were fine. I then went further to explain the reason for my coming and the family centered maternity care to them. They were really interested to know more. With permission I inspect their room and it was neatly kept, their windows and doors were strictly covered with net which could protect the whole family from mosquito bite and their surroundings were neat. I asked of her previous complaint, which was loss of appetite which she said it was quite better.

I took the opportunity to educate her on true signs of labour, I also discuss with her birth preparedness and complication readiness. She gave me the chance to inspect her items (layette) for confinement. I congratulated her because everything had been purchased and were neatly arranged in a bag. The issue on transportation had been sorted out with her husband.

I then allowed them to ask questions but they asked none. They were very appreciative because according to them they had understood everything.

I reminded her on the date of the next follow up visit and I also encouraged her husband to come along with her. I encouraged her husband to continue supporting her with the household chores. I then thanked them for their cooperation and reminded them of the next antenatal visit to the clinic. I asked permission to leave, which they saw me off around 6:00pm.

SUBSEQUENT ANTENATAL VISIT TO THE CLINIC

Madam A.R. reported to the antenatal clinic on 3/12/2020 at 10:00am. She was warmly welcomed and enquiries were made about the welfare of her family. Which she said they were doing well but complained of fatique, waist pain and lower abdominal. and she was reassured that the lower abdominal pain was due to descent of the foetal head into pelvis which is normal in pregnancy and waist pain is because the foetus was pressing against the sacroiliac joint.

She was taken through the routine procedure and had the following readings:

Temperature	36.0^0C
Pulse	80 bpm
Respiration	22cpm
Blood pressure	110/60mmHg

Laboratory investigation

Haemoglobin level	12.0g/dl
Urine Routine Examination	No abnormality

She was weighed and record as 79.5kg

Urine Routine Examination done and No abnormalities detected.

The procedure and purpose for all examination were explained to her, she was then asked to empty her bladder and privacy was ensured. I therefore washed and dried my hands and performed head to toe examination but no abnormalities like oedema or jaundice was found. She was healthy looking.

On inspection the abdomen was globular` in shape and fetal movement was present. On palpation, Symphysio - fundal height was 36cm, lie was longitudinal, presentation was cephalic, descent was $5/5^{th}$ above the pelvic brim and gestational age was 36 week.

On auscultation the fetal heart rate was 142bpm with normal rhythm. The findings were communicated to her. I therefore thanked her and aided her from the examination couch. Madam A.R. was offered a seat. Hand washing was done before the findings were recorded in her antenatal card.

She was encouraged to continue with her medication as prescribed. I then saw her to the gate and bade her goodbye.

On the 10/12/2020 at 8:30am, Madam A.R reported again to the clinic with her husband. They were welcomed and offered a seat and I asked about their wellbeing and they replied that they were doing well. She complained of constipation and frequency of micturition and was reassured that frequency of micturition will reduced that it was pressure of the foetal head on the bladder. I also encouraged my client to have enough rest at least 1-2 hours in a day and educated her to support the abdomen with pillow when sleeping, also I educated her on baby care and breastfeeding. Her vital signs and observation were recorded as follows;

Temperature	36.6^0C
Respiration	22cpm
Pulse	76bpm
Blood pressure	110/70 mmHg

Her weight was also checked and recorded as 80.0kg

Laboratory Investigations

Urine Routine Examination done and no abnormalities detected.

The procedure and purpose for all examinations were explained to her and she was asked to empty her bladder and privacy was observed. I washed and dried my hands and performed head to toe examination on her but no abnormality was detected.

On inspection the abdomen was globular in shape with the presence of linea nigra and straie gravidarium. Symphysio- fundal height was 37cm, the lie was longitudinal, presentation was cephalic, descent was $5/5^{th}$ above the pelvic brim and gestational age was 38weeks. Fetal movement was present on palpation.

On auscultation the fetal heart rate was 145bpm with normal rhythm. The findings were communicated to her and was reminded of follow up if she does not delivered within the week.

I then saw them off to the gate and bade them farewell.

SUBSEQUENT ANTENATAL HOME VISIT

Madam A.R and her family were visited on 7/12/2020 at 4:00pm. I met her husband and her mother-in- law. I was welcomed and offered a seat. Madam AR. I asked Madam A.R of her previous complain which is lower abdominal pain and fatique. She said its better and she is coping with it. I advised Madam A.R to take a lot of fluid and to do mild exercise like walking and to avoid strenuous activities like lifting of heavy objects and also to ensure good personal and environmental hygiene. I thanked her and the family and left.

On 14th december, 2020. Madam A.R and family were visited in the evening around 4:00pm. I met her husband, son and her mother- in- law, they were pleased to see me. I asked Madam A.R of her previous complain that is constipation and frequency of micturition, which she said is better and that she is coping with it. I therefore took this opportunity to encourage Mr. E.N and his mother to support Madam A.R in her condition and they assured me of their full support and care I educated her on the signs of labor which included appearance of show, painful rhythmic uterine contractions and rupture of membranes. I taught her deep breathing exercise to relieve pain during labour. She exhibited a clear understanding of what we discussed. They were much grateful with my visit and counseling and another visiting time was scheduled. I reminded her of her next visit to the clinic if she has not delivered within the week and I told her she should report to the maternity ward whenever she sees any signs of labour. I thanked her and the family and I left.

NURSING CARE PLAN DURING ANTENATAL CARE

PROBLEMS IDENTIFIED

1. Client complained of lower abdominal pain.
2. Client complained of loss of appitite.
3. Client complained of fatique.
4. Client complained of constipation.
5. Client complained of frequency of micturition.

SHORT TERM GOAL

1. Client will experience reduction in lower abdominal pains within 24hrs evidence by client verbalizing reduction of pain
2. Client will demonstrate normal nutrition within 48hrs of intervention as evidence as evidence by client verbalizing that she regained normal appitite.
3. Client will maintained adequate energy level throughout labour as evidence by client being able to bear down effectively during second stage
4. Client will be relieved of constipation within 48hrs as evidenced by client verbalizing restoration of normal bowel movement.
5. Client will experience reduce frequency of micturition within 48hrs as evidence by client verbalizing reduction in frequency of micturition.

LONG TERM OBJECTIVES

Client will stay healthy throughout pregnancy without any complications to both mother and baby.

NURSING CARE PLAN DURING ANTENATAL

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
26/11/20 at 10:0	Acute pain(lower abdominal pain)related to descent of foetal head into maternal pelvis in late pregnancy .	Client will experience reduction in lower abdominal pains within 24hrs as evidence by client verbalizing reduction in pain	1.Reassure client that labor pain is a normal occurrence in pregnancy which is due to descent of the foetal head into the pelvis 2.Asses the severity of the pain 3.Advise client to avoid prolong standing and rather sit whiles performing house chores 4.Encourage her to have adequate rest and sleep.She should sleep at least 2-3hrs during the day and 8hrs during the night. 5.Advise client to empty bladder when she feels the urge. 6.Advise client to get up from bed slowly	1.Client was reassured that LAP is a normal occurrence in late pregnancy which is due to the descent of the foetal head into the pelvis 2.Severity of pain was assesed 3.Client was advised to avoid prolong standing and rather sit whilst performing house chores 4.Encourage her to have adequate rest and sleep.She should sleep at least 2-3hrs during the day,8hrs during the night 5.Client was advised to empty the bladder when she feels the urge 6.Client was advised to get up from bed slowly	7/12/2020	Goal fully met as evidence by client verbalizing reduction of labour pain.	B.P

NURSING CARE PLANE DURING ANTENATAL

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES	NURSING ORDERS	NURSING INTERVENTIONS	DATE AND TIME	EVALUATION	SIGN
3/12/2020 at 10:00am	Fatigue related stress of pregnancy	Client will be able to maintain adequate energy level throughout pregnancy as evidence by client being able to bear down effectively	1.Reassure client 2.Explain the causes of fatigue in labor 3.Encourage client to lie on her left side 4.Give sips of water that contains glucose to client.	1.Client was reassured 2.Causes of fatigue in labour were explained to client 3.Client was encouraged to lie on the left side to promote adequate blood flow. 3.Client was given sips of water with glucose to increase her energy level	19/12/2020 at 10:30pm	Goals fully met as client maintained adequate energy level and was able to bear down effectively during second stage of labour.	B.P

		during second stage of labour.	5.Encourage client to perform deep breathing exercise during contraction and rest in between	4.Client was encouraged to deep breathing exercise during contraction and rest in between			

NURSING CARE PLAN DURING ANTENATAL

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
10/12/20 at 10:30am	Urge urinary elimination (frequency of micturition) related to pressure of foetal head on urinary bladder	Client will be able to cope with the frequency of micturition within 48 hours till delivery as evidenced by client verbalizing that she is now coping with the	1. Reassure client that the condition is normal in pregnancy 2. Explain the cause of frequency of micturition to her 3.Advise her to avoid the intake of fluids just before bedtime 4. Advise her on the need to maintain perineal hygiene	1. Client was reassured that condition is normal in pregnancy 2. The cause of frequency of micturition was explained to her 3. Client was advised to avoid intake of fluids just before bedtime 4. Client was advised on the needs for maintaining perineal hygiene	12/12/20 at 4:00pm	Goal fully met as evidence by client verbalized her ability to cope with frequency of pregnancy	B.P.

		frequency of micturition.	5. Advice client to void anytime she felt the urge to 6. Advice client on the use of chamber pot at night	5. Client was advised to void anytime she feels the urge to 6. Client was advised on the use of chamber pot at night			

NURSING CARE PLAN DURING ANTENATAL

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
24/06/19 at 9:30am	Impaired comfort (heart burns) related to pressure of the growing fetus on the stomach and relaxation of the cardiac sphincter by progesterone.	Client will have a reduction in the intensity of heart burns within 24 hours as evidence by client verbalize relief of heart burns.	1. Reassured client 2. Explain the physiology to the client. 3. Encourage client to have small but frequent meals 4. Advised client to take warm water or milk to neutralize acid. 5.Educate client to sit on a stool or chair and avoid	1. Client was reassured. 2. Physiology was explained to client. 3. Client was encouraged to have small but frequent meals. 4. Client was encouraged to take warm water or milk to neutralized acid. 5. Client was educated to sit on a stool or on a chair and avoid	25/6/19 at 4:30pm	Goal fully met as client verbalized that she is able to cope with heart burns.	M.D

			bending down whilst performing household chores 6. Encourage her to prop up in bed and use more pillows while sleeping. 7. Encourage sitting for a while after eating before lying down	bending down whilst performing household chores. 6. Client was encouraged to prop up in bed and use more pillows while sleeping. 7. Client was encouraged to sit for while after eating before lying down.			

NURSING CARE PLAN DURING ANTENATAL

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
1/7/19 at 9:30am	Impaired comfort (waist pain) related to physiological changes in pregnancy	Client will be able to cope with waist pain within 48 hours as evidence by client verbalizing that she is coping with the intensity of waist pain.	1. Reassure client that her backache will reduce at least within 48 hours. 2 .Educated client on the physiology of the waist pain. 3. Educated client to avoid lifting of heavy object 5. Assess and educate client to wear low heel shoes.	1. Client was reassured that her backache will reduce at least within 48 hours. 2. Client was educated on the physiology of the waist pain. 3. Client was educated to avoid lifting of heavy object 5. Client was assessed and educated to wear low heel shoes.	3/07/19 at 9:30am	Goal fully met as evidenced by client verbalizing she can to cope with waist pain	M.J

			6. Encouraged clients to rest and sleep on firm mattress with comfortable position. 8. Encourage husband to give sacral massage.	6. Client was encouraged to sleep on firm mattress with a comfortable position. 8. Husband was encouraged to give sacral massage.			

CHAPTER THREE

LABOUR AND DELIVERY

Labour is the process by which viable fetus that is 28weeeks to 40weeks together with its placenta, membranes and liquor amini are expelled through the birth canal.

This chapter takes into account the management of madam A.R. through the first, second, third and fourth stage of labour as well as immediate and essential care of the baby. It also includes problem encountered during labour and how they were managed using the nursing process.

ADMISSION AND MANAGEMENT OF FIRST STAGE OF LABOUR

Madam A.R. reported at the hospital on 19/12/2020 at 5pm with the history of painful uterine contraction, waist and thigh pain. She was accompanied by the mother in-law. They were welcomed and offered seat .Her maternal health record was reviewed for any complication in previous child birth but none was found. I explained to them that the painful uterine was a sign of true labour and that it will be over with the birth of the baby. According to her she noticed a blood stained mucus discharge from the vagina about 3hours ago, she has not visited any health provider nor taken any drug before coming. Her last meal was akple and palm soup as at 4:30pm and she empty her bowel at 4:00.I enquired of any danger signs such as severe headache, persistent vomiting, oedema and any vaginal bleeding or discharge, she said there was none. Her estimated date of delivery was recalculated and HIV status was rechecked which was negative. All procedures and purposes for all examinations were explained to her.

Her vital signs were checked and recorded as;

Temperature 36.0^0C

Pulse	84bpm
Respiration	20cpm
Blood pressure	120/60mmHg

She was given a bedpan and privacy was provided with a screen. I told her to empty her bladder before the examination and also provide her with bottle to give a midstream urine. Urine passed was 120mls. I put on a mackintosh apron and gloves. I noted the quantity and colour was amber, smell for odour. The urine was tested for protein and glucose and all were negative

All necessary items needed for further assessment were assembled. Head to toe examination procedure was explained to her. Privacy was provided, Client was helped to undress and helped unto the examination couch. She was asked to lie on her side to prevent supine hypotension. I performed hand washing with soap and water and dried it with clean towel warmed my hands by rubbing and started the examination. This was done under the supervision of the midwife in charge. On head to toe examination, her conjunctiva was pink, neither oedema nor jaundice nor swelling of the neck were noticed. I explained the procedure for abdominal examination to her. I explained to her that the procedure will help me know the position and presentation of the foetus.

On abdominal inspection, the abdomen was globular in shape without scars, nor rashes. However Straie gravidarium linea nigra and foetal movement were present.

On abdominal examination, lie was longitudinal and gestational age 39 weeks plus 2 days. Fundal height was 38cm, presentation cephalic and head descent $3/5^{th}$ above the pelvic brim.

On auscultation, foetal heart rate was 139bpm with good rhythm. A tray was set for vaginal examination after the procedure was explained to her and her consent was sought. I helped the client to assume a

lithotomy position, draped her and vulva was exposed. I then washed my hands with soap and water and dried them up with clean towels. I wore a sterile glove and removed the soiled pad with my left hand. The vagina was examined at 5:30pm. I inspected the vulva and it was normal with no varicose veins scars and other abnormalities like warts, oedema were seen. I swabbed the labia majora using each gauze swab for each side swabbing from anterior to posterior. I swabbed the labi manora using the same procedure. I parted the labia manora and swabbed the vestibule with my right hand. I inserted my right middle first finger and added the index finger. The vagina was moist and warm with the cervix soft and well applied to the presenting part. The Os uteri was 5 centimeter dilated and the membrane were intact with no moulding. The ischia spines were blunt and the sacrum was well curved. When withdrawing my hand, I checked the milking of the urethra but no abnormal colour was detected. After the examination, the vulva and perineum was cleaned and I applied a clean perineal pad to the perineum and provided a comfortable bed for her in the labour ward. The progress of labour was explained to her using the dilatation board and she was reassured of the best of care washed my hand with soap and water, dried, with clean towel. Uterine contractions were 3 in 10 minutes lasting for 30- 38 seconds. She complained of lower abdominal pain and waist pain at 6:00pm. She was reassured all will resolve at the end of labour. Findings were recorded on the partograph and in her Maternal Health Record Book.

As labour progressed Madam A.R. was encouraged to urinate frequently. Foetal heart rate, contractions and maternal pulse were checked every 30 minutes while vaginal examination, head descent, blood pressure and temperature were checked 4 hourly The client was encouraged to do deep breathing exercise during uterine contraction and to avoid shouting. Madam A.R. exhibits signs of anxiety due to unknown outcome of delivery and complained of tiredness at 7:30pm. She was reassured and encouraged to empty her bladder frequently using the bedpan to help in the descent of foetal head . I also encouraged her to change her perineal pad when soiled and wash her hands before and after

changing the perineal pad to reduce the risk of infection. Her permission was sorted to time contractions to know the dilation of the cervix. Results of contraction was 3 in 10minutes lasting 30-40 seconds. I communicated the findings to her and recorded it on a partograph.

Labour was monitored till 9:00pm when uterine contractions become very strong and expulsive in nature and it was 4 in 10minutes lasting 50-55. There was spontaneous rupture of membranes at this time. Madam A.R. could no longer bear the pain complain of strong bearing down sensation. A second vagina examination was carried out and the cervix was fully dilated 10cm which a staff midwife confirms that it was fully dilated**.** Head descent was $0/5^{th}$ above the pelvic brim, liquor was clear, moulding was present, she was informed that her cervix has fully dilated and was reassured of safe delivery. The delivery trolley and resuscitation tray which had already been set was drawn nearer the couch, where she was positioned into lithotomy position. Foetal heart rate was 140bpm, and temperature was 36.2C, pulse 78bpm and blood pressure 110/60mmHg. Urine output was 100mls and urine sample tested negative for protein and sugar. I encouraged her to empty her bladder. Client was served with glucose water.

MANAGEMENT OF SECOND STAGE OF LABOUR

Protective clothes were worn that is boots. goggles, rubber apron and hands were scrubbed before putting on gloves in readiness of the delivery process. Afterwards Madam A.R. was cleaned from the umbilical area to the upper thigh with gauze soaked in savlon solution and draped with clean towel leaving only the perineum and vulva exposed. A clean pad was applied to anal region to prevent faecal matter from contamination the delivery field and also to support the perineum. She was instructed to bear down with contraction and rest in between to prevent exhaustion. The anus gapped to reveal the presenting part.With each contraction, the head advances gradually. Flexion of the was maintained by gently

pressing the occiput with the index and middle finger downwards to enable the smallest diameter pass through the perineum. This was to prevent perineal tears and trauma to the baby's head.

When the head crowned, Madam A.R. was asked to bearing down and pant, the face was slowly delivered by extension. This was to prevent sudden expulsion of the head and possible trauma to the perineum or the baby's head. The eyes were swabbed with sterile gauze from the inner canthus to the outer, nose and mouth were cleared of secretions to ensure patency of airway. I feel gently around the baby's neck for cord around the neck and there was none. I waited for restitution to take place which indicates internal rotation of the shoulder. When this occur, the anterior shoulder was delivered by applying gentle downward pressure on the head during subsequent contractions and lifting baby up towards the mothers abdomen for it to escape under the symphysis pubis and then deliver the posterior shoulder. The rest of the body was delivered by lateral flexion following the curve of carus onto the mother's abdomen. An alive male baby was born at 9:10pm on 19/12/2020.He cried lastly after birth. I congratulated Madam A.R. and baby was immediately dried and stimulated thoroughly with a clean cot sheet, baby was placed skin to skin on mother's abdomen and covered with warm cot sheet to prevent hypothermia. An assistant palpated the uterus for undiagnosed second twin and it was excluded. Injection oxytocin 10 units was immediately administered intramuscularly on the medio-lateral of the left thigh. With the baby on the mother's abdomen, I clamped the cord with two artery forceps and cut in between covering with a sterile gauze to prevent splashing of blood. I put the cut end in a kidney dish between the thighs of the mother close to the perineum. I showed the baby to the mother to identify the sex and she smile and said is a boy. Respiration was established and APGAR score was assessed and it reads 8/10 for the first minute and 9/10 for the fifth minutes. The baby was then wrapped and placed on the mothers to initiate breastfeeding.

IMMEDIATE CARE OF THE BABY AT BIRTH

The immediate care of the baby begins as soon as the head is born. The eyes were cleaned with sterile cotton wool swabs from the inner cantus to the outer cantus. The mouth and nose were suctioned with bulb syringe to clear the airway. The baby was wrapped him in a clean cot sheet to prevent hypothermia. I clamped the cord with two artery forceps away from the baby's abdomen and it was covered with sterile gauze to prevent blood from splashing unto the baby. Baby was separated from the mother and shown to her to identify the sex. The baby cried loudly. An identification band was placed on the wrist which includes the date and time of delivery and sex of the baby. APGAR score was assessed at the first and fifth minutes and were recorded as 8/10 and 9/10 respectively. The baby was put on the mother's abdomen to initiate skin to skin contact and covered for one hour to prevent him from getting cold, provide warmth and initiate breastfeeding and bonding.

MANAGEMENT OF THE THIRD STAGE OF LABOUR

The procedure was explained to her and Madam A.R. remained in lithotomy position and a sterile receiver was placed in between the thighs with the clamped end of the cord placed in it to receive the placenta and the blood clot after delivery, the abdomen was palpated to rule out undiagnosed second foetus and to ensure the bladder is empty. An injection oxytocin ten (10) units was given intramuscularly on the mediolateral side of thigh to aid contraction and to control bleeding. The uterus was palpated and when it becomes well contracted the cord was held together with the forceps in the middle to give it a good grip whilst the left hand was placed just above the symphysis pubis with the palm facing the mothers abdomen to give counter pressures. The placenta was delivered by controlled cord traction. When the placenta became visible at the vulva I received it into my cupped hands to ease pressure on the membranes. With gentle upward and downward movement, the membranes were coaxed out at 9:15 pm. Placental was quickly examined and on examination the lobes and membranes were complete and

healthy, was later placed in a receiver for a thorough examination. Blood clot was expelled to facilitate uterine contractions by massaging the uterus .The amount of blood loss was 120mls. The vulva, the vaginal wall and the perineum were inspected for tear and laceration but none was observed. Client was cleaned and new sanitary pad placed on the vulva and made her comfortable and congratulated her again for her co-operation. Instruments used for delivery were decontaminated in 0.5% chlorine solution for 10minutes before washing, rinsing, drying and sterilization. I removed my protective clothings, washed my hands with soap under running water and dried them with clean towel and documented every delivery report in the book and on the partograph.

EXAMINATION OF PLACENTA AND MEMBRANES

The placenta after expulsion was thoroughly examined to ensured membrane and lobes were intact. The placental was examined on a flat surface under a good source of light. The length was 48cm and weighed about 0.6kg.The cut end of the cord was observed and had two small arteries and one vein surrounded by wharton jelly. The placental was held by the cord up with membranes hanging freely. The cord was centrally inserted in the placental. The foetal surface was shiny and smooth with greyish blue colour. I spread my hand into the membranes and it reveal a single hole as a point of exit with no blood vessels running into it. I peeled the amnion from the chorion up to the point of insertion of the cord and it was complete. The membranes and the lobes were intact. The lobes were 20 in number and divided by sulci The maternal surface was dark red in color. There were no infarcts or calcification on the maternal surface and it was discarded the placenta container provided in the ward containing a bleach solution of $0.5^{0/0}$

MANAGEMENT OF THE FOURTH STAGE OF LABOUR

The fourth stage of labour is the first six hours after delivery of placenta. One hour in the labour ward and five hours in the lying-in-ward. It is a critical period for both the mother and the baby therefore;

there is the need for close monitoring to detect any change in their condition for immediate intervention. Madam A.R. and her baby's vital signs were checked and recorded every 15 minutes for the first 2 hour, then 30 minutes for the next 1hours, then hourly for the last 4 hour for the next 24 hours.

The mother's vital signs were recorded as follows:

Temperature	-	36.0^0C
Pulse	-	82bpm
Respiration	-	20cpm
Blood pressure	-	110/60mmHg

Measuring the symphysio fundal height was 18 centimeters above the symphysis pubis. The uterus was palpated regularly for contraction and client encouraged to be emptying the bladder often for the uterus to contract well to prevent postpartum haemorrhage. The colour of the lochia was bright red and the amount was moderate. She was asked to change her perineal pad whenever it is soaked and wash her hands before and after changing pad to prevent infection. She should also inform the staff when she notices heavy bleeding. Madam A.R. was encouraged to breastfeed her baby well as it help in creating bonding and help the uterus to contract. She was also encouraged to keep the baby warm and catch some sleep when the baby is asleep to relief herself from the stress of labour; Client was served with fufu and light soup whiles in the lying in ward.

Observation made on the baby

Temperature	-	36.7^0C
Apex beat	-	139bpm

Respiration - 40cpm

Appearance - Pink

Cord - No bleeding

The baby was weighed and his weight was 3.4kg. Injection Vitamin K 1mg was given intramuscularly at the right thigh and tetracycline ointment was used on the eyes from the inner canthus to the outer canthus and chlorhexidine gel was applied to the cord. The baby passed meconium and urine once indicating patency of the anus and the urethra. Suckling and swallowing reflexes were present since the baby suckled the breast well. She was counseled on exclusive breastfeeding and infection prevention. Both the mother and baby are in good condition. They were transferred to the lying ward after the one hour observation in labour ward and they were monitored for the rest five hours.

SUMMARY OF LABOUR NOTE

Madam A. R. $G2P1^{A}$ with 39 weeks + 2 days gestation, had a spontaneous vaginal delivery to a live male infant on 19th December, 2020 at 9:10pm .Birth weight was 3.4kg. Apgar score was 8/10 and 9/10. Injection oxytocin 10 IU was given at the left mediolateral thigh of the mother at 9:02pm. Placenta and membranes were completely expelled at 9:15pm by control cord traction. Placenta weighed 0.6kg. Mother and baby were in good condition.

DURATION OF LABOUR

DATE	**STAGES OF LABOUR**	**FROM**	**TO**	**DURATION**
	1st stage	2:00pm	9:00pm	7 hours
	2nd stage	9:00pm	9:10pm	10 minutes

19th DECEMBER, 2020	3rd stage	9:10pm	9:15pm	05 minutes
	TOTAL			7 hours, 15 minutes

CONDITION OF MOTHER AFTER DELIVERY	
Condition of mother	Satisfactory
Placenta and membrane	completely expelled
Condition of perineum	Intact
Uterus	well contracted
Temperature	36.0°C
Blood pressure	110/60mmHg
Pulse rate	82bpm
Respiration	20cpm
Fundal height	18cm

CONDITION OF THE PLACENTA	
Lobes and membranes	completely healthy
Cord insertion	centrally situated
Cord Length	48cm

Weight of Placenta	0.6kg
Diameter	20cm
Maternal surface	Dark red
Foetal surface	Bluish grey
Cord vessels three	One (1) vein and two (2) arteries

CONDITION OF BABY AFTER DELIVERY	
Condition of baby	Satisfactory
Sex of baby	Male
Birth weight	3.4kg
Head circumference	34cm
Chest circumference	32cm
Full length	52cm
Apgar score	First minutes 8/10, fifth minutes 9/10

Skin colour	Pink
Activity	Active
Abnormalities detected	None
Meconium	Passed
Urine	Passed

NURSING CARE PLAN DURING LABOUR

PROBLEMS IDENTIFIED

1. Client complained of lower abdominal pain.
2. Client complained of waist pain
3. Client complained of fatique
4. Client is at risk of infection
5. Client looks anxious.

SHORT TERM NURSING OBJECTIVES

1. Client will be cope with lower abdominal pain by the end of labour..
2. Client will be able to cope with waist pain till the end of labour.
3. Client will maintained adequate energy level throughout labour.
4. Client will be free from infection throughout labor
5. Client's anxiety will be allayed within 2 hours.

LONG TERM NURSING OBJECTIVES

Client will go through labour and deliver alive and healthy baby without complications to mother and the baby

NURSING CARE PLAN DURING LABOUR

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING ITERVENTION	DATE AND TIME	EVALUATION	SIGN
19/12/2020 at 5:00pm	Acute pain (lower abdominal pain) related to painful uterine contraction.	Client will cope with lower abdominal pain within 4 hours as evidenced by client verbalizing that she is coping with lower abdominal pain.	1. Reassure client of safe delivery. 2. Explain to the client the physiology of labour and the cause of pain. 3. Encourage client to do deep breathing exercise during contraction. 4. Allow client to adopt a comfortable position except supine.	1. Client was reassured of safe delivery. 2. The physiology of labour and the cause of pain were explained to client. 3. Client was encouraged to do deep breathing exercise during contraction. 4. Client was allowed to assume comfortable position except supine.	19/12/2020 at 9:10pm	Goal fully, met as client as was able to endure the pain throughout labour	B.P

			5. Massage the client's sacral region. 6. Divert client's attention from pain by engaging her in conversation.	5. Clients sacral region was massaged. 6. Clients attention was diverted from pain by engaging her in conversation.			

NURSING CARE PLAN DURING LABOUR

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
19/12/2020 at 5;00pm	Impaired comfort (waist pain) related to descent of the fetal head and uterine contraction.	The client will be able to cope with backache within 4 hours as evidence by client verbalizing that she is able to cope with the waist pain	1. Reassure client that, she will be relieved of waist pain soon after delivery. 2. Encouraged client to cope with the condition since it is temporal and diverts client's attention. 3. Explain physiology behind waist pain to client. 4. Massage client's sacral region during contraction.	1. Client was reassured that she will be relieved of waist pain soon after delivery. 2. Client was encouraged to cope with the condition since it is temporal and client attention was diverted 3. Physiology behind waist pain was explained to client. 4. Clients sacral region was massaged during contraction.	19/12/2020 at 9:10pm	Goal fully met as evidence by client verbalizing she was able to cope with backache.	B.P.

			5. Encouraged client to adopt comfortable position. 6. Encouraged client on deep breathing exercise.	5. Client was encouraged to adopt comfortable position. 6. Client was encouraged on deep breathing exercise.			

NURSING CARE PLAN DURING LABOUR

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
19/12/2020 at 5:00pm	Anxiety related to unknown outcome of labour.	Client will be allayed of anxiety within 4 hours as evidence by client showing cheerful facial expression and calmness.	1. Provide emotional support to client by telling her she is in competent hand. 2. Encourage the client to verbalize her concern feelings and fears. 3. Explain every procedure to be carried out on her in clear and simple terms. 4. Address client concerns appropriately.	1. Client was provided with emotional support by telling her she is in competent hand. 2. Client was encouraged to verbalize her concern feelings and fears. 3. Procedure to be carried out on clients was explained in clear and simple terms. 4. Clients concerns were addressed appropriately.	19/12/2020 at 9:10pm	Goal fully met as evidenced by client showing cheerful facial expression and calmness.	M.D

			5. Keep client informed about progress of labour. 6. Engage client in conversation to take her mind off labour.	5. Client was kept informed about progress of labour. 6. Client was engaged in conservation to take her mind off labour.			

NURSING CARE PLAN DURING LABOUR

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
19/12/2020 at 5:00pm	Fatigue related to increased physical stress and strains of labour.	The client will have energy throughout labour as evidenced by client being able to bear down effectively during the second stage of labour and going through labour successfully.	1. Reassure client that fatigue will resolve at the end of labour. 2. Provide a quite environment to reduces stressors which helps promote rest. 3. Plan care with minimal interference to maximizes opportunities for rest. 4. Served client with sips of water that contain glucose to	1. Client was reassured that fatigue will resolve at the end of labour. 2. Quite environment was provided to reduce stressors which help promote rest. 3. Care was planned with minimal interference to maximizes opportunities for rest. 4. Client was served with sips of water that contains glucose to let	19/12/2020 at 9:10pm	Goal fully met as evidence by client showing good maternal effort in second stage till the end of labour	B.P.

			let her maintain energy throughout labour. 5.Provide encouragement for effort the client makes to help client maintain maximal effort	her maintain energy throughout labour. 5.Encouragement was provided for the client effort to make her maintained maximal effort.			

NURSING CARE PLAN DURING LABOUR

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
19/12/2020 at 5:00pm	Risk of infection related to invasive procedures.	Client will t be free from infection throughout labour and peuperium as evidenced by	1.Reassure client of competent care. 2.Educate client on proper hand washing which reduces the risk of spreading infective agent.	1. Client was reassured of competent care. 2.Client was educated on proper hand washing which reduces the risk of spreading infective agent.	19/12/2020 at 9:10pm	Goal fully met as evidenced by client not having any signs of infection as at discharge.	M.D

		client having no signs of infection such as fever and chills	3.Avoid frequent vagina examination to reduce the incidence of ascending tract infection. 4.Use aseptic technique during vagina examination to limit contaminant from reaching the vagina. 5.Provide oral and parenteral fluids to maintain hydration and general sense of well being.	3.Frequent vagina examination was avoided to reduce the incidence of ascending tract infection. 4.Aseptic technique was used during vagina examination to limit contaminant from reaching the vagina. 5Oral and parenteral fluids was provided to maintained hydration and a general sense of well being.			

CHAPTER FOUR

PUERPERIUM

This chapter talks about the care and support offered to Madam G. H and her baby during the puerperium. They were monitored critically for early detection and management of any abnormality. They were visited twice daily at home on the first, second and third day after delivery. On the fourth to the seventh day after delivery, she was visited daily at home and on the tenth day she reported at the postnatal clinic for examination and I handed over to the public health team.

MANAGEMENT OF PUERPERIUM

DAY OF DELIVERY

Madam G. H on the 6th July, 2019 was monitored an hour before transferred to the lying in ward after delivery, she was assisted in a wheel chair into her bed. Baby was wrapped in a warm cloth and placed at mother side, 30 minutes later, breastfeeding was initiated, she was then served with fufu with light soup by the mother in-law at her request.

Uterus was palpated, fundal height was 17cm and was well contracted, lochia was rubra and moderate. She was encourage to urinate frequently, change her pad frequently especially when seen soiled to prevent infection.

Madam G. H was educated to breastfeed her baby frequently but she complained of lower abdominal pains whenever she breastfed the baby. She was reassured that is because the uterus is returning to its pre-pregnant state and the pain is temporal. I explained the physiology of lower abdominal pain to client and also educate client to continue breastfeeding baby on demand. Prescribed analgesic was served. She did well, as I observed her positioning her baby to breast, I also observed the baby for any abnormal behavioral change of which there was none. No abnormality detected on both mother and baby on the day of delivery. Baby suckled well, which indicated that the suckling and

swallowing reflexes were present. Meconium and urine was passed confirming the patency of the urethra and anal orifice.

SUBSEQUENT CARE OF MOTHER AND BABY DURING PUERPERIUM

Madam G. H and her baby were made comfortable in a warm bed in the lying in-ward where continuous observations were made in order to detect any abnormality or change. I congratulated her, she was also happy about the sex of the baby. I informed them that they will be discharged as soon as the mother and baby's condition were satisfactory. They were informed that the bill will be taken care of by National Health Insurance Scheme. This really made them smiled. My clieny was made comfortable in bed. She informed me she has urinated two times. Baby's weight was 3.1kg. Her vital signs were monitored every 15minutes for two hours, 30minutes for another one hour then, hourly for three hours then 4 hourly till discharged.

MOTHER

Temperature	-	36.4^{o}C
Pulse rate	-	82bpm
Respiration	-	22cpm
Blood pressure	-	100/60mmHg

BABY

Temperature	-	36.5^{o}C
Apex heart beat	-	140bpm
Skin colour	-	Pink
Reflexes	-	Present
Respiration	-	40cpm

Urine passed was also noted. All findings and procedures were recorded appropriately.

EXAMINATION OF THE BABY

I explained procedures and the reasons for the baby examination to Madam G. H and sought her permission to examine her from head to toe to exclude any abnormalities. A tray containing the following was used for the examination.

- A sterile gallipot containing sterile cotton wool swab.
- A cord ligature, scissors, tape measure, gloves and plastic apron.

All the windows to the room were closed to prevent hypothermia. I wore my plastic apron and washed my hands with soap under running water and dried them with clean towel and wore my gloves. The baby was wrapped in a clean cot sheet and put on a flat surface under a bright light and I ensured that only the part to be examined was exposed at a time, taking note of the general appearance. The baby was lying in a dorsal position with the knees flexed. The colour of the skin was pink and was covered with vernix caseosa with skin folds. Skin lesion, peelings, swelling and lanugos were absent.

On examination, the skull bones were normal. There was no caput succedaneum, the sutures and fontanelles were soft and not widening. There was no laceration on the face and the head was covered with enough hair. The upper borders of the ears, nose, were patent with no discharge and were in line with the canthus of the eyes. There were no growth, polyps and bloody discharges in the ears. The rooting and suckling reflex was stimulated and mouth was opened for inspection. There was no cleft lip or cleft palate or no tongue tie and the lips were pink.

On examination of the neck there were no swellings, there were no thyroid gland seen on the neck with no stiffness. The chest was barrel in shaped. I observed the rising and falling movement of the chest to confirm good respiration. The breasts were palpated and no abnormality such as lump was seen with erected nipple. The upper extremities were of equal length and the palm had palmar creases. The nails were developed and at a level of the tip of the fingers. They were of equal size

and no extra digit or webbed fingers. Moro and grasping reflexes were present. The abdomen had no rashes. It was round with normal tone. The umbilical cord, on inspection was not bleeding or protruding. The cord has three vessels, two arteries and one vein. The bladder was normal since it was not felt abdominally. There was no distention of the abdomen and testes had descended into the scrotum.

Examination of the anus revealed no abnormalities. Meconium and urine was passed to confirm the patency of the urethral and anal canal. The lower extremities, the legs and feet were of equal length. There were five toes on each foot. The baby was placed in a lateral position and the spinal Colum was normally positioned without any abnormities on examination. It was intact with no growth, swelling or missing vertebrae. The baby was weighed and measured. The following were the recordings:

Head circumference	-	33cm
Full length	-	52cm
Chest circumference	-	32cm
Birth weight	-	3.1kg

Baby was dressed up wrapped in a warm cot sheet and given to mother to breastfeed. Findings were communicated to mother and recorded on the baby's chart. I thanked my client and decontaminated items in 0.5% chlorine solution for 10minutes after which they were washed and dried.

BABY'S FIRST BATH

The following morning, I prepared warm water for the baby's bath. I then explained the procedure to my client about the bathing of the baby and assembled the items such as baby soap, sponge, towel, socks, dress, baby oil or Vaseline, diapers and a warm cot sheet. I mixed and tested temperature of water with my elbow after which I put on a plastic apron.

My hands were washed with soap under running water and dried them with clean towel after which sterile gloves were worn. Baby was placed on a protected flat surface, undressed and wrapped with a cot sheet. Baby's eyes were cleaned with a sterile cotton wool swab soaked in clean water from inner canthus to the outer canthus and face was cleaned with damp face towel and dried. I then plugged baby's ears with two fingers of my hands supporting baby's head, washed head with soapy sponge, lifted baby off flat surface supporting the nape with the body resting in the elbow, then I rinsed and dried soap off the baby's hair. Baby was placed on the protected flat surface, exposed the arms and front of the trunk and was washed with much attention to the skin folds. I turned the baby's back with one arm supporting the chest with hands holding the distal arm of the baby and I washed back down to feet with much attention to the skin folds. Baby was supported firmly, immersed into the bath of warm water with head above water and rinsed thoroughly.

After this, I placed baby on flat surface covered with clean warm sheet. I used a small towel to dry baby, paying attention to the skin folds. The baby's cord was dressed and with this, my gloves were changed and new one was put on and cord was exposed. I held the tip of the cord with clean cotton wool swab after I had inspected it for bleeding. The base of the cord was cleaned in a circular motion and the whole cord was cleaned with fresh sterile dry cotton wool swab, soaked in methylated spirit from the base upwards. The tip of the cord was dried with separate dry cotton wool swab and the cord ,i removed my gloves,washed my hands and I put on a disposable gloves and baby oil was smear, diaper was worn and folded below the umbilicus and was dressed . The baby was given to mother and she was educated not to touch or apply anything to the cord. Used items and working surface was decontaminated whiles soiled swabs and gloves were disposed as required. I washed my hands with soap under running water and dried them with clean towel.

PREPARATION TOWARDS DISCHARGE

Madam G. H delivered on 6th July, 2019 and was told she will be discharged in the morning which was on the 7th July, 2019. Preparation was made towards her discharge. Education was given to client, her mother, and the husband on how to top and tail baby and how to dress the cord of the baby till it falls off. She was informed to take special care of the baby's skin folds. I educated client to ensure diaper are kept away from cord. Also I discouraged them from applying any local herbs, chalk and salt or any substance to the cord as this could lead to the infection of the cord. I taught them to use only methylated spirit to clean the cord.

They were taught to clean from the base upward. I informed her to report immediately if she notices any bleeding and abnormal behavior of the baby or any abnormality on herself. I educated them that, the cord will separate faster when kept clean and dry always. I also informed them that, I will be dressing the cord daily during my visit to her at home. I educated them on the importance of exclusive breastfeeding to baby and mother for a period of six months.

I also taught her how to breastfeed her baby, by washing hands with soap under running water and dry them with clean towel before breastfeeding to prevent infection. I encouraged her to sit on a comfortable chair that will help her rest her back or she could sit on low seat and rest the back and put the legs on a small stool when breastfeeding. When sleeping or in bed, she should turned the baby's body towards her with its abdomen touching her abdomen and should support and keep her baby's shoulder in alignment. The head should be in between the arms and her hands should also go under the baby's buttocks. She was informed to stimulate the rooting reflex with the nipple on baby's chest and should wait until he opens his mouth wide and quickly fix the breast to the baby. She was also informed to ensure that, greater part of the areola is in baby's mouth. Also client was informed to ensure her baby's chin is in contact with her breast and baby's lower jaw is turned outwards. She should also observe for swallowing reflex and she should also look in to baby's eyes when

breastfeeding. I also informed her that when baby is feeding, she should allow baby to empty one breast before giving the other breast. She should also break wind by gently rubbing baby's back after each feed. I also told her after feeding she should nurse baby on her side to help drain any secretions from baby's mouth. She should wash hands with soap and water and dry them with clean towel after feeding. Madam G. H was encouraged to change soiled diapers regularly and apply Vaseline on the baby's buttocks to prevent rashes at the perineal area. She was also informed to ensure napkins are washed and dried in the sun and also baby's dresses are washed before the mother's clothes.

I educated my client to dress baby with long sleeve during the cold weather and I also educated her on the need to register the baby at the Birth and Death Registry after 21 days.

I encouraged her mother to assist her so that she can have enough time to rest at least 2 hours a day. I encouraged her to take a lot of fruit with high roughage and vegetables to prevent constipation. She was also encouraged to eat high protein diet to repair worn out tissues and also to boost her hemoglobin level. Frequent intake fluid was encouraged to prevent dehydration. I encouraged my client to wear clean clothes and under wear to prevent infection. Also, well-fitting brassier with adjustable broad straps to support the breast was encouraged. She was informed to maintain good personal hygiene by bathing twice daily, changing of perineal pads frequently and also remember to wash hands with soap under running water before and after changing perineal pad. She was informed to also observe the flow of lochia for colour, odour, amount and consistency and also report any abnormality. She was educated to observe baby's cord for colour, odour discharge and bleeding and report any change immediately. Mother alleged she urinated twice but did not passed stool whiles baby passed stool once and urinated twice.

She was given the following prescribed medication

Capsule Amoxicillin	500mg tds for 7 days
Tablet paracetamol	1000mg tds for 3 days

Tablet folic acid	5 mg daily for 30 days
Tablet fersolate	200mg daily for 30 days
Tablet multivitamin	200mg daily for 30 days

She was congratulated for her effort once again.

Vital signs checked and recorded as Temperature-36.5ºC, Pulse-80bpm, Respiration 22cpm, and Blood/Pressure-110/60mmHg. I informed them of my visit to the house twice daily for the first three days and daily from the fourth day to the seventh day postnatal and will be handed over to the public health team on the tenth day. I went to the record section for the claim sheet, filled it and gave it back to the record officer and they were discharged in the admission and discharge book at 11:45am. I also thanked them for their cooperation and informed her I will be visiting her again in the house to examine them. They also thanked the staff including myself for their care.

EVENING

I visited my client in the evening at 4:30pm as I promised to continue with my observations. I was welcome by her husband and her mother in-law and they offered me a seat to make me comfortable and went to inform my client of my presence. We then exchanged pleasantries and I asked how they were coping. They responded positively and were happy about the baby. Mother alleged she urinated twice and did not passed stool whiles baby passed stool twice and urinated twice. Madam G. H said she ate banku and groundnut soup. I sorted permission to carry on with the observation on both the mother and her baby. I realized that both were in good health as confirmed by client. Lochia was red with moderate flow. After this, baby was dressed up, wrapped and given to the mother to breastfeed. I encourage client to breastfeed baby on demand and especially at night to make the practice of the lactation amenorrhea method (LAM) effective for six months to prevent pregnancy. I also encouraged her to take her prescribed drugs, take more water, fruits to help move her bowel and to

have enough rest and sleep. I thank the whole family for their warm reception and promised to visit the next day in the morning. I also wished them sound sleep and said good bye.

Vital sign checked and recorded as follows;

MOTHER			**BABY**	
Temperature	-	36.6^{o}C	Temperature	36.5^{0}C
Pulse	-	79bpm	Apex heart rate	139bpm
Respiration	-	20cpm	Respiration	40cpm
Blood pressure	-	110/70mmHg		

Mother's fundal height is measured and recorded as 18cm.

SECOND DAY POST NATAL VISIT

I visited Madam G. H and the family 7:30am in the morning on the 8th July, 2019.They were happy to see me again. I asked about their health and she said by the grace of God they were all doing well. I explained procedure to mother and I washed my hands with soap and water and dried them with clean towel. On examination of the head, there was no cephal haematoma. No discoloration on the eyes, . The ears were with no discharge. The nose was inspected and the septum was clear, there were no polyps or discharges. The nostrils were patent. The mouth was inspected and there was no sore or redness in the mouth.

However suckling, swallowing reflex, rooting reflex were present. The neck was with no swelling or growth. The hands were of equal length. Grasping and more reflexes were also present. The cord was not bleeding and there was no offensive odour. There were no rashes on the skin. The general condition of the baby was good. I top and tailed the baby, dressed him and exposed the cord to dry; cord was dressed with methylated spirit and sterile cotton wool swab. Baby was wrapped in a new cot sheet and cords left opened to air dry. Baby was then given to mother to breastfeed. Mother was

examined but no abnormality was detected. The breast was lactating well with no engorgement. Lochia was inspected for colour which is rubra, consistency, amount and odour which were all normal. Mother alleged she urinated twice but did not pass stool whiles baby passed stool twice and urinated twice. Findings were communicated to her.

I asked if she has any question but she said no, she complained of insufficient sleep due to excessive cry of the baby at night and constipation. I reassured her and educated her to eat a lot of fruits and vegetables and at least drink eight glasses of water a day. I encouraged her to feed the baby until the baby is full, I also encouraged the mother in-law to help in the care of the baby and other chores. I advised her to sleep while the baby is asleep so that when the baby is awake she can also be awake to meet the needs. I encouraged my client to position baby well to breast and feed baby on demand. Educate client to change wet diapers or napkins of the baby. Vital signs were taken and recorded.

EVENING

In the evening I visited my client again in the home at 4:30pm. She was seated outside. I asked about the family and everybody was doing well. I was offered a seat and enquired about what she took for supper and she said fufu and palmnut soup. I enquired about the after pains and she said she no longer feel the pains. Procedure for head to toe examination was explained to the mother.

After that, I asked permission to check her vital signs of her and the baby which she agreed. I recorded it. I inspected the baby's cord and it was dry. I also topped and tailed baby after which I dressed baby`s cord with sterile cotton wool swab and methylated spirit. The baby was dressed and cord was exposed to air dry and baby was wrapped in a new cot sheet. Mother was examined but no abnormality was detected. Mother alleged she urinated twice and did not passed stool whiles baby

passed stool twice and urinated twice. Fundal height was measured and recorded 17cm. All finding were recorded. I thank them and asked permission to leave.

MOTHER

VITAL SIGNS	**MORNING**	**EVENING**
Blood pressure	110/70mmHg	110/60mmHg
Temperature	36.4ºC	36.5ºC
Pulse rate	82bpm	81bpm
Respiration	20cpm	22 cpm

BABY

VITAL SIGNS	**MORNING**	**EVENING**
Temperature	36.4^0C	36.5^0C
Apex beat	142bpm	140bpm
Respiration	44cpm	42cpm

THIRD DAY POSTNATAL VISIT

Madam G. H and her baby were dressed in white clothing when I visited them at 7:30am for their third postnatal care on 9th July, 2019. Client complained of tiredness and backache. She was reassured and the physiology of tiredness and backache was explained to her. Also, mother in-law and husband were encouraged to help in caring for the baby and doing the household chores.

I asked about the insomnia and she said she could sleep 2 hours during the day Procedures were explained to my client to perform head to toe examination. I washed my hands with soap under running water and dried them with clean towel. On general examination from head to toe of the baby, the skin was pink in colour with no rashes. The sutures and fontanelles were normal with no swelling on the head.

There were no discharge from the eyes, ears and nose. The sclera was clear and conjunctiva was pink. The abdomen was soft on palpation. Baby looked healthy, cheerful and very active. The cord was not completely dropped, so, I dressed the cord with sterile cotton wool swab and methylated spirit and exposed to air dry. According to the mother, baby pass stool two times and urine was two times. I assisted her to top and tail baby and dressed the baby's cord with methylated spirit.

He was able to suckle well and he weighed 3.0kg. The baby's vital signs checked and recorded as follows:

MORNING		
Temperature	-	36.5^0C
Apex beat	-	138bpm
Respiration	-	43cpm

MOTHER

Procedure was explained to mother to do head to toe examination on her. Mother was asked to empty her bladder. I then washed my hands with soap and water and dried them with clean towel. Madam G. H was examined from head to toe. Her hair was neatly plaited, face looked healthy, eyes were clean with pink conjunctiva, her neck and breast was normal with no abnormality. There was no tenderness, pain or swelling in her calf. Upon palpation of the uterus, it remained firm and well

contracted. Client did not move her bowel but urinated twice. I washed my hands with soap under running water and dried them with clean towel. I wore sterile gloves to inspect the perineum and lochia. On the perineum there was no discharges, scar or swelling seen. On inspection the lochia was rubra in colour. I thanked her and I removed my gloves. I washed my hands with soap under running water and dried them with clean towel. I then discussed my findings with her. I taught her postnatal exercises such as pelvic rock exercise, head and shoulder lift exercise, rib cage lift exercise and she was supervised to do them since they will promote circulation, strengthen abdominal muscles, drainage of lochia and facilitate the return of the reproductive organs to their non-pregnant state. Health education talk was given on exclusive breastfeeding for six (6) months. Some of the benefits were enumerated that; it promotes bonding, protection against disease. I also advised her on personal hygiene by bathing twice daily, changing perineal pad frequently and also washing hands before and after changing the perineal pad and before breastfeeding.

I thanked her for her co-operation and reminded her of birth registration after 21 days. All findings were recorded as follows:

MOTHER'S VITAL SIGNS CHECKED AND RECORDED

Blood pressure	110/60mmHg
Temperature	36.4^0C
Pulse rate	79bpm
Respiration	20bpm

EVENING

I visited her in the evening at 4:30pm to find out how they are doing. I was warmly welcome on arrival. I enquire how they were faring and she said they were well. Procedure for head to toe examination of both mother and baby was explained to her. Baby was examined from head to toe with particular attention to the colour and the eyes, no abnormality was detected. I assisted the mother to topped and tailed the baby, dressed the cord with methylated spirit. The mother was examined and no abnormality was detected, History was taken on stool pattern and urine elimination. Mother alleged she urinated twice and passed stool once whiles baby passed stool once and urinated twice. Findings were communicated to her. She had her bath and took banku with okra soup for supper. The fundal height was measured with tape measure and the symphysio fundal height measured 16cm, this shows the uterus was involution well. I asked if she had any question and she said no. I then thanked her and the family and left at 5:00pm. Both baby and mother's vital signs were checked and recorded as follows

VITAL SIGNS	**MOTHER**	**BABY**
Temperature	36.7^0C	36.5^0C
Pulse	78bpm	136bpm
Respiration	20cpm	40cpm
Blood pressure	110/60mmhg	

FOURTH TO SEVENTH DAY POSTNATAL HOME VISIT

(10th to 13th July, 2019)

On the 10th July, 2019 at 4:30pm I visited the family again for the continuation of the assessment. We exchanged greetings and she offered me a seat. Procedure for head to toe examination of both mother and baby was explained to her. Baby was examined from head to toe with particular attention to the colour and the eyes, no abnormality was detected. I assisted the mother to topped and tailed

the baby I was told baby passed stool twice and urinated four times and mother passed stool once and urinated thrice. Fundal height was measured and recorded 14cm. Vital signs were checked and recorded. There were no signs of anaemia and involution of the uterus was on-going. Lochia was serosa and moderate. Client was able to demonstrate the importance of postnatal exercise and practiced it effectively. I thanked her for her cooperation and reminded her of my visit in the evening the observation on mother and baby was recorded as follows;

VITAL SIGNS	**MOTHER**	**BABY**
Temperature	36.7^0C	36.4^0C
Pulse	79bpm	138bpm
Respiration	20bpm	40bpm
Blood pressure	110/60mmHg	

On the fifth day 11th July 2019 at 4:00pm, Madam G. H and her family were visited. We exchanged greetings and she offered me a seat. She told me that the baby's cord fell off and I cleaned the stamped aseptically. Madam G. H and her mother in law was taught how to dress the cord the stump and was advise to wash her hands thoroughly before and after dressing the stump. I told Madam G. H and her mother in law that baby bath can start from the next day. I asked permission to carry out my routine examination. Madam G. H went to empty her bladder and I examined her from head to toe, no abnormalities were detected, her breast was lactating well. I asked mother about their elimination pattern and she said baby passed stool thrice and urinated four times and she passed stool twice and urinated thrice. Mother was encouraged to continue taking more water and fiber foods. Baby was also examined and no abnormalities was detected but noticed none. Baby was weighed and recorded 3.1kg. Mother's fundal height measured 13cm.Vital signs were communicated to them.

VITAL SIGNS	MOTHER	BABY
Temperature	36.5^0C	36.4^0C
Pulse	79bpm	139bpm
Respiration	21bpm	42bpm
Blood pressure	110/70mmHg	

On the sixth day 12th July, 2019, I visited Madam G. H and the family at 4:30pm I enquired about their health and she said they are all well. I took the opportunity to educate them on good nutrition and environmental hygiene. She said she passed stool twice and urinated thrice and baby pass stool thrice and urinated thrice. Lochia was serosa and moderate. Mothers fundal height measured 13cm and finding communicated to them.

VITAL SIGNS	MOTHER	BABY
Temperature	36.8^0C	36.6^0C
Pulse	82bpm	140bpm
Respiration	22bpm	41bpm
Blood pressure	100/70mmHg	

On the seventh day 13th July, 2019. I visited the family again at 4:30pm. Mother and baby were examined and no abnormalities were detected. Baby passed urine 4 times and stool twice and mother passed stool once and urinated thrice alleged by mother. Baby was bathed and stump was dressed under aseptic technique. Baby was weighed and recorded 3.2kg. Mother's fundal height measured 10cm. Baby was dressed and wrapped in warm cot sheet and handed over to the mother. I told them

the scheduled home visit has come to an end but I will visit occasionally. I encouraged her and the family not to hesitate to report any abnormalities noticed on her or baby to the clinic. Madam G. H was encouraged to continue with the postnatal exercise and to have enough rest and sleep. She and the husband were also reminded of the tenth day postnatal clinic and family planning. Vitals on both mother and baby checked and recorded as follows

VITAL SIGNS	**MOTHER**	**BABY**
Temperature	36.6◦c	36.7OC
Pulse	82bpm	138bpm
Respiration	22bpm	42bpm
Blood pressure	110/70mmHg	

I congratulated the whole family especially the mother in-law for their support and was urged to continue supporting her. I expressed my warmly gratitude to Madam G. H, her husband Mr. A.A and the whole family. I then told them today mark the last day of my official home visit and reminded them on the tenth day clinic visit which I will hand them over to the public health team for continuity of care.

TENTH DAY POSTNATAL VISIT

Madam G. H and her mother inlaw reported at the clinic on the 16th July, 2019 at 8:30am and they were all dressed in white clothing. I welcomed them and offered a seat. We were all happy to see each other once again. I asked of their health and that of the family. She said they were all doing well. Specimen bottle was given for collection of urine specimen for urinal analysis, and laboratory

form issued for laboratory investigation such as haemoglobin level estimation, malaria parasite, protein urea and glucose. Their vital signs were checked and recorded as follows;

VITAL SIGNS	MOTHER	BABY
Temperature	36.6^{o}C	36.5^{O}C
Pulse	80bpm	139bpm
Respiration	20cpm	43cpm
Blood Pressure	100/60mmHg	-

Permission was sought to examine both mother and baby. She accepted and the procedure was explained. She was asked to empty her bladder and privacy provided. Hands were washed and dried. I helped her to lie on the examination bed in the dorsal position. Her hair was neatly tied with face neither oedematous nor puffy. Her conjunctiva was pink; Ears and nose were free from discharge; Mouth was clean and there was no enlarged lymph node palpated. The breasts were lactating well and there was no lump felt on examination. Upper limbs were equal while the nail beds were neat and pink in colour. The abdomen was inspected and palpated and there was no abnormality detected. Fundal height was 7cm. The lower extremities were equal with no oedema or tenderness. I helped her to lie on the lateral side and examined the back. I gently tapped the flank angle with a close fist and no pain was felt. I ran my index and middle fingers along the spine and there was no depression. her vulva inspected and there was no abnormality. Perineal pad was not offensive on inspection. Lochia was alba in colour. I helped her out of the examination bed and helped her to dress up and her weight was 74kg. Laboratory investigation results were as follows;

Haemoglobin level - 11.8g/dl

Urine for protein and glucose - Negative

Malaria parasite - Negative

Stool - Negative

The baby was examined from head to toe. I washed and dried hands and then put on examination gloves. Baby was undressed, wrapped in a cot sheet and put on a flat surface in the presence of the client and her mother. A quick inspection was done and baby's skin was pink with no rashes. The head was examined and the fontanelles were neither bulging nor sunken. Baby's eyes were free from discharge. The conjunctiva was pink. His mouth was clean with no oral thrush observed. Ears were free from discharge and pain. There was no enlarged lymph node felt on palpating the neck. Both breasts were normally situated with no engorgement. The abdomen was soft and umbilical cord stump was almost healed. The extremities as well as the back were normal with no abnormality detected. According to mother, baby had passed urine and yellowish stool and his weight was 3.4kg.All findings were communicated to them. I congratulated my client's mother for taking good care of mother and baby. I reminded her of the importance of attending child welfare clinic and the next postnatal visit date. Emphasis was laid on all health educational topics that we discussed. I encouraged her to continue to maintain personal hygiene of the baby and also to visit the Reproductive and Child Health for continuity of care and immunization against the childhood preventable diseases from six weeks of birth onwards. I encouraged her to register the baby at the birth and death registry. They were very happy for the care rendered to them.

I expressed my profound gratitude to Madam G. H and her family later in the evening for their time, support, kindness, and co-operation and wished them the best of luck.

NURSING CARE PLAN DURING PUERPERIUM

PROBLEMS IDENTIFIED

1. Client complained of lower abdominal pain
2. Client complained of inadequate sleep.
3. Client complained of fatigue
4. Client complained of backache
5. Client complained of constipation

SHORT TERM OBJECTIVES

1. Client will be relieved of pain within 24 hours.
2. Client will be able to sleep 2 hours during the day and 6 to 8 hours during the night within 24 hours.
3. Client will be relieved of fatigue within 24 hours
4. Client will be relieved of backache within 48 hours.
5. Client will be relieved of constipation within 48 hours.

LONG TERM OBJECTIVES

Client will go through puerperium successfully without any complications to both mother and baby.

NURSING CARE PLAN DURING PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
6/7/19 at 5:00pm	Acute pain (after pain) related to involution of the uterus.	Client will be relieved from pain within 48 hours of puerperium as evidenced by client verbalizing reduction in pain.	1. Reassure client that pain is temporal. 2. Explain the physiology of lower abdominal pain to client. 3. Educate client to continue breastfeeding on demand despite the pain. 4. Teach and encourage client to do postnatal exercise	1. Client was reassured that the pain was temporal. 2. The physiology of the lower abdominal pain was explained to her. 3. Client was educated to continue breastfeeding baby on demand to fasten involution. 4. Client was taught and encouraged to do postnatal exercise.	8/07/19 at 5:00pm	Goal fully met as evidenced by client verbalizing that she is relieved of pain.	M.D

			5. Encourage client to take enough rest. 6. Encourage client to empty her bladder to aid in involution. 7. Served prescribe analgesic like tablet paracetamol 1g to relieve pain.	5. Client was encouraged to take enough rest. 6. Client was encouraged to empty her bladder to aid in involution. 7. Prescribed analgesic paracetamol 1000mg was served to the client.			

NURSING CARE PLAN DURING PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
8/7/19 at 7:30am	Insomnia related to baby crying at night.	Client sleeping pattern will be improved at least 24 hours as evidenced by client verbalizing sleeping at least 8 hours nocte.	1. Reassure the client that she will be sleeping normally. 2. Explain the causes behind baby's cry to mother. 3. Encourage client to feed the baby well and on demand. 4. Advise client to find time to sleep when baby is also sleeping especially in the day. 5. Encourage her mother-in-law or husband to help in caring for the baby.	1. Client was reassured on her sleeping pattern. 2. The causes behind baby's cry was explained to mother. 3. Client was encouraged to feed baby well and on demand. 4. Client was advised on the time to sleep when baby is also asleep during the day. 5. Client's mother-in-law and husband were encouraged to help in caring for the baby.	9/7/19 at 7:30am	Goal fully met as client verbalized that she slept at least 8 hours at night	M.D

NURSING CARE PLAN DURING PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES /OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
9/07/19 at 7:30am	Fatigue related to exclusive breastfeeding and care of the baby.	Client will experience relief of tiredness within 24 hours as evidenced by client verbalizing relief from tiredness.	1. Reassure client. 2. Encourage client on the need for rest and sleep. 3. Encourage her mother and husband to help in most of the house chores. 4Educated client to limit the number of visitors to enable her have long sleeping periods during the day.	1. Client was reassured. 2. Client was encourage on the need for rest and sleep 3. Client was encourage to let her mother and husband to help most of the house chores. 4. Client was educated to limit the number of visitors to enable her have long sleeping periods during the day. 5. Client was encouraged to keep her environment quite at all time.	10/7/19 at 7:30am	Goals fully met as client looked cheerful and verbalized fatigue reduced after enough rest and sleep.	M.D

			5. Encourage client to keep her environment quite at all time.				

NURSING CARE PLAN DURING PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
9/07/19 at 7:30am	Backache related to improper positing of baby during breastfeeding.	Client will be relieved of backache within 48 hours as evidenced by client verbalizing being relieved of backache.	1. Reassure client that she will be relieved of backache 2. Encourage client to sit upright and rest her back on a pillow when breastfeeding baby. 3. Teach and supervise client to use other positions example, lying down on the side to breastfeed. 4. Supervise client to properly attach baby to breast. 5. Educate client to wear low	1. Client was reassured that she will be relieved of backache 2. Client was encourage to sit upright and rest her back on a pillow when breastfeeding baby. 3. Client was taught and supervised to use other positions example, lying down on the side to breastfeed. 4. Client was supervised to properly attach baby to breast.	11/7/19 at 7:30am	Goal fully met as client verbalized of relieve of backache.	M.D

			heeled shoes. 6. Educate client to let somebody help her when lifting heavy objects.	5. Client was educated to wear low heeled shoes 6. Client was educated to let somebody help her when lifting heavy objects.			

NURSING CARE PLAN DURING PUERPERIUM

DATE AND TIME	NURSING DIAGNOSIS	NURSING OBJECTIVES/ OUTCOME CRITERIA	NURSING ORDERS	NURSING INTERVENTION	DATE AND TIME	EVALUATION	SIGN
8/7/19 at 7:30am	Constipation related to effect of progesterone on the gut.	Client will regain her normal bowel within 48 hours as evidenced by client verbalizing it.	1. Educate client to eat enough fibre and roughage to aid in free bowel movement. eg. Banana, kontomire. 2. Encourage client to take in more fluid at least 8 glasses of water in a day. 3. Educate client to take a lot of warm water in the morning before breakfast.	1. Client was educated to eat enough fibre and roughage to aid in free bowel movement. Eg. banana, kontomire 2. Client was encouraged to take in more fluid at least 8 glasses of water in a day. 3. Client was educated to take a lot of warm water in the morning before breakfast.	10/7/19 at 7:30am	Goal fully met as client verbalized she was able to move her bowel.	M.D

			4. Educate client to do exercise such as walking.	4. Client was educated to do exercise such as walking.			

TERMINATION OF CARE

This is where the period of relationship, which had been established between the midwife and the client comes to an end. This started from the first encounter with Madam G. H on the 17th June, 2019 when I met her. She was informed and assured of quality care throughout pregnancy, labour and puerperium. She was however made aware that the care would be terminated after tenth day of postnatal visit to the clinic and will hand her and her baby over to the Public Health Team and the midwives for continuity of care. Madam G. H was introduced to the Public Health team in-charge of the reproductive and child health unit at St. Luks Clinic on the 16th of July, 2019. Madam G. H was informed to call me anytime she needed my assistance. I reminded her of the six weeks subsequent postnatal clinic visit for continuity of care and registration of baby at the Birth and Death Registry. She was advised to keep to the baby's immunization schedule, maintain personal and environmental hygiene, and abides by the health education given and not to forget to report to the hospital anytime she has a problem before her review date.

I thanked Madam G. H and her family for their co-operation, support, patient for the family centered maternity care study. Client also thanked me on behalf of her family for the care and support given to them. My encounter with Madam G. H on the Family Centered Maternity Care Study came to an end on 16th July, 2019.

SUMMARY AND CONCLUSION

This family centered maternity care study was rendered to Madam G. H a 28 years old pregnant woman Gravida 2 Para 1 alive at Chenderi in the Krachi Nchumuru District. I first met her at the St. Luks Clinic (Maternity wing) when she was 36 weeks pregnant on 17th June, 2019. Care was provided till term, through labour and puerperium. The client had a spontaneous vaginal delivery on 6/07/ 2019. She delivered a live healthy male infant at 4:00pm with birth weight 3.1kg without any abnormality or complications.

Madam G. H puerperal period was devoid of problem. She practiced exclusive breastfeeding and this made the baby gained weight steadily. Madam G. H was finally discharged on 7th July, 2019 after spending a day. She was followed up in the house in the form of home visit till 13th July, 2019 the seventh day for continuity of care.

The care was carried out on the entire family in their own environment; thus their natural setting. The nursing process was used to identify their needs and problems that were peculiar to them and solution were fund to resolve them. This family centered health care enabled me to render quality health care to the client as well as her family. The knowledge acquired throughout this process has equipped me with better understanding in the care of an expectant mother and her family as a whole and this will go a long way to enhance my career as a midwife.

APPENDICES

APPENDIX I: ANTENATAL PROGRESS REPORT

APPENDIX II: LABORATORY INVESTIGATION

DATE	SPECIMEN	INVESTIGATION	RESULT	NORMAL VALUES	REMARK
15/02/18	Blood	Hemoglobin level.	11.9g/dl	10 – 16g/dl	Normal
		Malaria parasite	No malaria parasite	Negative	Normal
		Sickling	seen	Negative	Normal
		Grouping and across matching	Negative	Negative	Normal
		Rhesus factor	"O"		
	Urine	Protein	"D" positive	Negative	Normal
		Glucose	Negative	Negative	Normal
		Acetone	Negative	Negative	Normal
	Stool	Routine Examination	Negative	Negative	Normal
			No ova seen		
13/04/18	Blood	Malaria parasite	No malaria parasite	Negative	Normal
			seen		
	Blood	Haemoglobin level	12g/dl	10-16g/dl	Normal
	Urine	Protein	Negative		Normal

		Glucose Acetone	Negative Negative		Normal Normal
8/06/18	Blood	Haemoglobin level Malaria parasite	12 g/dl No malaria parasite seen	10 – 16 g/dl Negative	Normal
	Urine	Protein Glucose Acetone	Negative Negative Negative	Negative Negative Negative	Normal Normal Normal

LABORATORY INVESTIGATIONS IN LABOUR

DATE	SPECIMEN	TYPE OF INVESTIGATION	RESULT	REMARK
28/06/18	Urine	Protein Glucose Acetone Albumin	Negative Negative Negative Negative	Normal Normal Normal Normal

LABORATORY INVESTIGATIONS IN PUERPERIUM

DATE	SPECIMEN	INVESTIGATIONS	NORMAL RANGE	RESULTS	REMARKS
8/07/2018	Blood Urine	Hemoglobin level Protein Sugar	11-16g/dl Negative Negative	11. 8g/dl Negative Negative	Normal Normal Normal

APPENDIX III: PARTOGRAPH

APPENDIX IV: APGAR SCORE ON BABY

CONDITION	**1ST MINUTES**	**5TH MINUTES**
APPEARANCE	2	2
PULSE	2	2
GRIMCE	1	1
ACTIVITY	1	2
RESPIRATION	2	2
TOTAL	**8/10**	**9/10**

APPENDIX V: DURATION OF LABOUR

DATE	STAGES OF LABOUR	FROM	TO	DURATION
6th July, 2019	1st stage	9:40am	3:40pm	6 hours
	2nd stage	3:40pm	4:00pm	20 minutes
	3rd stage	4:00pm	4:05pm	05 minutes
	TOTAL			6 hours, 25 minutes

APPENDIX VI: EXAMINATION OF PLACENTA AND MEMBRANES

Lobes and membranes	-	completely healthy
Cord insertion	-	centrally situated
Cord Length	-	50cm
Weight of Placenta	-	0.5kg
Diameter	-	20cm
Maternal surface	-	Dark red
Foetal surface	-	Bluish grey
Cord vessels three	-	One (1) vein and two (2) arteries

APPENDIX VII: EXAMINATION AND MEASUREMENT OF BABY

Condition of baby	-	Satisfactory
Sex of baby	-	Male
Birth weight	-	3.1kg
Head circumference	-	33cm
Chest circumference	-	32cm
Full length	-	52cm
Apgar score	-	First minutes 8/10, fifth minutes 9/10
Skin colour	-	Pink
Activity	-	Active
Abnormalities detected	-	None
Meconium	-	Passed
Urine	-	Passed

APPENDIX V: SIX HOURS OBSERVATION OF MOTHER AND BABY

APPENDIX IX: REPORT ON THE BABY 'WEIGHT CHART

APPENDIX X: REPORT ON THE MOTHER

APPENDIX XI: POSTNATAL HOME VISITS OBSERVATIONS AND RECORDINGS ON MOTHER AND BABY DURING EARLY PUERPERIUM

APPENDIX XII: PHARMACOLOGY OF DRUGS USED IN PREGNANCY

DRUG	DOSAGE	ROUTE OF ADMINISTRATION	CLASSIFICATION	MODE OF ACTION	SIDE EFFECTS	EFFCT ON CLIENT
Tablet folic acid	5mg daily for 30	oral	Vitamins	Stimulate formation of red blood cell	Anorexia, nausea and flatulence	No side effects reported
Tablet multivite	200mg daily for 30	oral	Vitamins	Aids metabolism. Formation of red blood cells.	Gastrointestinal upset (diarrheoa)	No side effect reported
Tablet ferrous sulphate	200mg daily for 30	Oral	Haematinics	Increase haemoglobin formation	Nausea, epigastric pain, vomiting and black stool.	Client reported passage of black stool

Tablet Sulphadoxine pyrimethamine	3tablets each for 5 doses	oral	Anti-malaria	Destroys malaria parasite	Gastrointestinal upset	No side effects was reported

PHARMACOLOGY OF DRUGS USED IN LABOUR

DRUG	**DOSAGE**	**ROUTE OF ADMINISTRATION**	**CLASSIFICATION**	**MODE OF ACTION**	**SIDE EFFECTS**	**EFFECT ON CLIENT**
Injection oxytocin	10 units	Intramuscular	Oxytocin drug	Stimulates uterine and mammary smooth muscles.	Hypertonic uterine action, rupture of uterus.	No side effect was noticed Uterus was well contracted.
Chlorine solution	0.5%	External use	Decontaminant	Destroys microorganisms such as bacteria.	Burning sensation	No side effect was reported.

Injection vitamin K	1mg	Orally	Anti-haemorrhagic	Promotes blood clotting and prevents bleeding.	No side effects	No side effect was reported.
Chloramp-henicol eye drop	1mg	Instillation	Antibiotic	Interferes with bacterial activity.	Redness of the eye	No side effect was reported.

APPENDIX XII^{C}: PHARMACOLOGY OF DRUGS USED IN PUERPERIUM- MOTHER

DRUG	DOSAGE	ROUTE OF ADMINITRATION	CLASSIFICATION	MODE OF ACTION	SIDE EFFECTS	EFFECT ON CLIENT
Tablet folic acid	5mg daily for 30	Oral	Vitamin	. Stimulate formation of red blood cells.	Anorexia, nausea and flatulence	No side effect reported
Tablet multivite	200mg daily for 30	Oral	Vitamin	Aids metabolism. Formation of red blood cells.	Gastrointestinalupset (diarrheoa)	No side effect reported

Tablet ferrous sulpate	200mg daily for 30	Oral	Haematinics	Increase haemoglobin formation	Nausea, epigastric pain, vomiting and black stool.	Client reported passage of stool
Amoxicillin	500mg tds for 5/7	Oral	Atibotics	To treat infections caused by bacteria	Vomiting,rash.diarrhea,nause	No side effect was noticed

PHARMACOLOGY OF DRUGS USED IN PUERPERIUM- BABY

DRUG	**DOSAGE**	**ROUTE OF ADMINISTRATION**	**CLASSIFICATION**	**MODE OF ACTION**	**SIDE EFFECTS**	**EFFECTS ON CLIENTS**

Bacilli Calmette Guerin [BCG]	0.05mi	Intra-dermal	Vaccine	Promotes immunity against tuberculosis.	Abscess formation Nausea.	Baby cried for some time after the injection.
Oral polio O	2drops	Oral	Vaccine	Produces immunity against poliomyelitis.	Vomiting, diarrhoea, fever.	No side effect was reported.
Methylated spirit	Quantity needed	External use	Antiseptic	Quick drying effect inhibit the medium of the growth of microbes	Burning sensation on the skin especially who applied to a broken skin	Baby's cord was kept dry and free from sepsis

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SIGNATORIES