Maternity Skills Lab Manual

(NRS 362)

Maternal-Newborn Health Nursing Skills And Procedures

Maternal-Newborn Health Nursing Skills And Procedures

(NRS 362)

INDEX

Unit – 1

Procedures Done During Antepartum Period

PROCEDURE 1: Perform first physical examination during pregnancy

PROCEDURE 2: Perform abdominal examination during pregnancy using Leopold maneuvers

PROCEDURE 3: Testing urine for protein & sugar using urinary dipstick

PROCEDURE 4: Assessing pitting edema

PROCEDURE 1: Perform first physical examination during pregnancy

Purpose:

1. To assess the woman's overall health status
2. To assess medical and obstetrical condition which indicate risk factors
3. To use the obtained information as baseline for comparison at subsequent examination

Procedure : The first physical Examination during pregnancy

1. Equipment

- Stethoscope
- Light measuring device
- Thermometer
- Sphygmomanometer
- Tongue depressor
- Weighing scale
- Urine testing facility
- Client record

Procedure

1. Prepare equipment

2. Welcome the woman
3. Instruct her to evacuate the bladder and collect a midstream specimen of urine
4- Test urine for sugar ,protein and Ketone
5- Measure accurately woman's weight without shoes
6- Measure accurately woman's height without shoes
7- Measure correctly her blood pressure
8- Measure correctly her pulse
9- Please the woman on the examination couch on her back
10- Explain the procedure to her
11- Drape the woman and keep the doors and curtains closed
12- Wash your hand
13- Stand at the right side of the woman
14- Examine the head .
    - Check hair for lice and nits
    - Check the face for pallor ,edema and facial expression
    - Check conjunctiva for degree of redness
    - Note any pigmentation on forehead and cheeks
    - Examine mouth for condition of gums and teeth
15- Examine the neck :
    Palpate the nodes below the posterior angle of the jawbone
    Check the neck for the thyroid gland
16- Examination the chest
    Assist with examination of the heart and lung by preparing the woman

Examination the breast ,nipple and areola

17- Examine the abdomen

18- Examine the extremities

- Check the color of the palms and nails
- Check swelling of fingers
- Examine the legs ,ankles and feet for shape and unequal length
- Check edema over the tibia,ankle and feet
- Observe legs for dilated veins

19- Assist with pelvic examination

20- Check the woman for danger signs of pregnancy

21- Assist the woman to get down from examination table and redress her clothes

22- Record findings and woman's reaction

.

23- Replace equipment's

24- Wash hands

25- Give the woman the necessary instruction and date of the next visit

26- Refer abnormal case

PROCEDURE 2: Perform abdominal examination during pregnancy using Leopold maneuvers

Purpose :

1. To detect any abnormality of the abdominal organs
2. To confirm pregnancy
3. To estimate the period of gestation
4. To determine presentation ,lie .position and engagement of the presenting part
5. To detect any deviation from normal

Procedure : Abdominal Examination

Preparation

1. Equipment

- Tap measure
- Pinard fetoscope or sonic fetal heart sound device
- Client record

Procedure

1. Prepare equipment
2. Welcome the woman
3. Preparing mother
4- Instruct her to evacuate the bladder
5- Positioning mother on her back on a firm bed or examination table
6- Standing at the side of bed, facing the mother during the first three maneuver but in the last one the nurse reverses her position and faces her feet.

7- **First Maneuver**

- Ascertaining the fundus and determined its level Gently palpate the fundus with the tips of the Fingers of both hands in oreder to define which fetal part is present in the fundus

8- **Second Maneuver**

Applying the palm of the hands on either side of the mother abdomen gentle but deep pressure is exerted to locate the back of the fetus in relation to the right and left sides of the mother.

9-. **Third Maneuver**

Employing the thumb and fingers grasping the lower portion of the maternal abdomen, just above symphysis pubis to determine if the presenting part is engaged or not

10- **Fourth Maneuver**

- Facing the mother’s feet, using the tips of the first three fingers of each hand, making deep pressure in the direction of the axis of the pelvic inlet to ascertain presenting part of the engaged head.
- Identifying the fetal position correctly.
- identifying which best place to hear the fetal heart tone.
- Hearing the fetal heart tone and count.

11-. *** Auscultation**

- Place the pinard fetal stethoscope at right angles about 5 cm above the head on the side of abdomen where the back was felt, keep the ear in firm contact with the pinard, don't touch it while listening. Listen carefully and count for 60 seconds.

PROCEDURE 3: Testing urine for protein & sugar using urinary dipstick

Objectives:

- To test for the presence of sugar and albumen in the urine.
- To determine the amount of glucose and albumen in the urine.
- To diagnose diabetes mellitus.
- To diagnose toxemia of pregnancy.
- To evaluate the effect of treatment given and progress of recovery.

Procedure : <u>Testing Urine for protein &Sugar using urinary dipstick</u>

1. Equipment

- Clinistix reagent strips
- Gloves
- Special container for collecting urine

Procedure

1. Prepare equipment
2. Welcome the woman
3. Explain the procedure to her
4. Instruct her to evacuate the bladder and collect a midstream specimen of urine in Special container
5- Dip a dipstick in the urine and compare the test result color with the color comparison chart provided on the reagent strip bottle.
6- Remove gloves
7- Wash hands
8- Record test time and finding
9- Interpret test outcomes and explain it to the woman

PROCEDURE 1: Assessing pitting edema

Procedure : <u>Assessing pitting edema</u>

Procedure

1. Explain the procedure & its purpose to the mother.
2. Screen the mother's bed.
3- Ask the women & family members if the women's face or hands appear swollen.
4- Inspect the women's face, extremities and sacral area for signs of pitting edema
5- Press each area firmly with thumb or index finger for several seconds & release.
6- Evaluate the Extensiveness of edema, Depth of depression & Length of time it takes to clear.
7- Grade the pitting edema according to the following scale
   1+ =minimal edema of lower extremities
   2+ =marked edema of lower extremities
   3+ =edema of the lower extremities, face & hands
   4+ =generalized, massive edema
8- Record your findings & compare your findings with those previously recorded

Unit – 2

Procedures done during intrapartum period

Procedure 1: Assessment of uterine contractions (1st stage of labor)

Procedure 2: Auscultating fetal heart rate during labor

Procedure 3: Vaginal examination during labor

Procedure 4: External electronic fetal monitoring

Procedure 5: Monitoring woman during labor (2nd and 3rd stages of labor)

Procedure 6: Immediate newborn care

Procedure 7: Apgar scoring

PROCEDURE 1: Assessment of Uterine Contractions (1st stage of labor)

Objectives:

1. To determine whether a contraction pattern typical of true labor.
2. To identify abnormal contraction that may jeopardize the health of the mother or fetus.
3. To prevent health hazards which mother be exposed.
4. To detect, diagnose & provide proper management of any hazards as early as possible.

Preparation of patient & equipment's

1. Explain procedure to the woman.
2. Ensure woman's bladder is empty.
3. Assemble equipment's:
   - Screen
   - Wrist watch
   - Stethoscope / Doppler
   - Put the mother in dorsal recumbent position & screen mother bed.

Procedure

1. Assist the woman to relax by encouraging her to breathe naturally & to take deep breaths during contractions.
2. Place fingertips of one hand on uterus, keep fingertips relatively still rather than moving them over uterus.
3. Note time when each contraction begins & ends to determine-
   - Frequency by calculation average time that elapses from beginning of one contraction until beginning of next one.
   - Duration by noting average time in seconds from beginning to end of each contraction.
   - Interval by noting average time between end of one contraction & beginning of the next one.
4. Auscultate fetal heart rate after each contraction reading.
5. Monitor the vital signs for the woman.
6. Observe the woman for any abnormal uterine contractions and fetal heart rate.
7. Wash hands and document the finding.

Procedure 2: Auscultating fetal heart rate during labor

Objectives:

1. To listen and count fetal heart rate.
2. To identify any abnormal fetal heart rate (tachycardia & bradycardia)

Preparation of patient & equipment's

1. Explain procedure to the woman.
2. Ensure woman's bladder is empty.
3. Assemble equipment's:

- Doppler device
- Ultrasonic gel

4. uncover the women's abdomen

Procedure steps

1. Place the ultrasonic gel on the diaphragm of the Doppler.
2. Place the Doppler diaphragm on the woman's abdomen halfway between the umbilicus and symphysis and in the midline.
3. Check the woman's pulse against the fetal sounds you hear. If the rates are the same, reposition the Doppler.
4. If the rates are not similar, count the FHR for 1 full minute.
5. Auscultate the FHR between, during and for 30 seconds following a uterine contraction.
6. Document the fetal heart rate count.

Procedure 3: Vaginal examination during labor

Objectives:

1. To determining the following:
   - ✓ Condition & Dilatation of the cervix.
   - ✓ Station & position of the presenting part.
   - ✓ Relationship of the fetus to the pelvis.
   - ✓ Early diagnosis of abnormal presentation.
2. To identify complications as Cord prolapsed, Placenta previa, etc.

Preparation of patient & equipment's

1. Explain procedure to the woman & maintain privacy.
2. Ensure woman's bladder is empty.
3. Assemble equipment's:
   - Sterile gloves
   - Screen
   - Lubricating jelly
   - Antiseptic solution (Dettol / savlon)
   - Sterile pad
4. Assist woman into supine position on exam table with lower extremities flexed and rotated outward, her heels should be supported in stirrup which are level with the table about 1 - 2 Ft in front of her buttocks [Lithotomy position].
5. Assist the woman to relax by encouraging her to breathe naturally.

Procedure steps

1. Expose the perineal area for examination.
2. Prepare the area with antiseptic solution.
3. Put on gloves, from standing position-using thumb & fore finger of non-dominant hand to spread the labia.
4. Insert the well-lubricated index & middle fingers of dominant hand into the vagina until they touch the cervix, using downward & upward direction, keep thumb of dominant hand upward, and supported on vulva.
5. Note presentation, position of fetus, cervical dilatation& effacement, station of fetal head, status of membranes.
6. Provide care with antiseptic solution & put on sterile pad after care.
7. Remove the equipment & gloves.
8. Wash hands and document the finding.

Procedure 4: External Electronic Fetal Monitoring

Objectives:

1. To identify any abnormal fetal heart rate (tachycardia & bradycardia)

Preparation of patient & equipments

1. Explain procedure to the woman.

2. Assemble equipments:
   - Monitor
   - Two elastic monitor belts
   - Tocodynamometer
   - Ultrasound transducer
   - Ultrasonic gel

Procedure

1. Turn on the monitor.
2. Place the two elastic belts around the woman's abdomen.
3. Place the tocodynamometer over the uterine fundus off the midline on the area palpated to be most firm during contractions. Secure it with one of the elastic belts.
4. Note the uterine contraction tracing. The resting tone tracing should be recording on the 10 or 15 mm Hg pressure line.
5. Apply the ultrasonic gel to the diaphragm of the ultrasound transducer.
6. Place the diaphragm on the maternal abdomen in the midline between the umbilicus and the symphysis pubis.
7. Listen for the FHR.
8. When the FHR is located, attach the second elastic belt snugly to the transducer.
9. Place the following information on the beginning of the fetal monitor paper: date, time, woman's name, gravida, para, membrane status and name of doctor & nurse- midwife.
10. Document about maternal and fetal condition.

Procedure 5: Monitoring woman during labor (2nd and 3rd stages of labor)

Objectives:

1. To maintain sterile field during labor.
2. To maintain health promotion of mother & fetus.
3. To prevent health hazards which mother & fetus may be exposed.
4. To detect & provide proper management of any hazards as early as possible.

Preparation of patient & equipment's

1. Explain procedure to the woman & maintain privacy.
2. Check good place, light & complete equipment.
3. Assemble equipment's:
4. 2 gowns, 2 gloves, 2 masks.
5. 5 towels.
6. Dressing & tissue gauze.
7. Foley's Catheter.
8. Sterile pads
9. Antiseptic solution
10. Syringes; one for local anesthesia & one for methargin.
11. Instruments; 2 kochers, 2 artery forceps, 2 scissors, 1 needle holder, 1 tissue forceps, toothed & non
12. Chromic catgut suture.
13. Newborn tray; cord clamp, identification band, suction tube, alcohol swab, scissor, eye drop, towel.
14. Put mother in lithotomy position.
15. Monitor progress of labor (maternal & fetal condition) and identify signs of 2nd stage of labor.

Procedure steps

1. Put on mask, overhead & scrubbing, gowning & gloving.
2. Expose the perineal area for examination.
3. Prepare the area with antiseptic solution.
4. Drape the mother.
5. Evacuate mother's bladder by catheterization.
6. Perform P/V examination to know the progress of labor.
7. Instruct mother to bear down during contraction & relax in-between.
8. Prepare the syringe for local anesthesia.
9. Observe presenting part for crowning occur.
10. When 3 - 4 cm of the head appears during uterine contraction perform right mediolateral episiotomy.
11. Support perineum with sterile dressing & maintain good flexion of the fetal head at the same time.
12. Deliver head & expulsion of fetal body.

13. Clamp and cut the umbilical cord at least one minute after birth: clamp the umbilical cord at about 3 cm from the baby's umbilicus and apply a second clamp at 2 cm distally to the first one. Lift the clamped cord and cut it in between the two clamps.
14. Show the baby to mother and hand over the newborn to other staff to give immediate care of newborn.
15. Observe the woman for signs of placental separation.
16. Wait for spontaneous expulsion of placenta otherwise deliver the placenta by controlled cord traction
17. Administer inj. Methargin following the delivery of placenta.
18. Perform examination of placenta & its membranes for completeness & any abnormalities.
19. Perform fundal massage to make it firm and remove the clots coming from uterus.
20. Give perineal care & change the towel under the mother.
21. Ensure the uterus is well contracted.
22. Observe episiotomy site for bleeders and repair episiotomy in three layers.
23. Provide perineal care with antiseptic swabs and put sterile pad.
24. Remove all towels and clean the mother.
25. Instruct the mother to lie supine with legs crossed.
26. Observe the woman for any complications like PPH, shock.
27. Collect equipment & clean instrument.
28. Wash hands & send the delivery sets to sterilization.
29. Report and record the procedure & condition of mother & baby.

Procedure 2.6: Immediate newborn care

Objectives:

1. To ensure an airway & maintain respiration.
2. To prevent cold stress (hypothermia).
3. To provide a time for complete observation.
4. To stimulate circulation as adequate to maintain health.
5. To keep the skin of the baby clean & in good condition.

1. Keep the room warm.
2. Assemble equipment's:
   - Vaccum suction, sterile catheter & oxygen.
   - Cord ligature or clamp.
   - Sterile scissor & artery.
   - Warm sterile towel.
   - Rectal thermometer
   - Cotton balls.
   - Bath of water at 37 ^{0}C
   - Alcohol 70%.
   - Gauze
   - Birth record
   - Eye drop.

1 Wash hands and wear gloves.

2 Put the newborn under radiant warmer in side lying or trendlenburg position to prevent aspiration of secretions.

Procedure

1. Dry the baby thoroughly and remove the wet linen.
2. If needed suction the mouth first and then the nose gently.
3. Use sterile plastic clamp or ligature, the first ligature is placed about 2 inch from the abdomen & second ligature is placed about 1 cm from the first ligature. Cut the cord by blunt sterile scissor after the second knot. Examine umbilical cord structure.
4. Complete **1** minute & **5** minute Apgar score.
5. Measure vital signs pulse, respiration & temperature.
6. Measure length, weight, head circumference, chest circumference & abdominal circumference.
7. Place Identification tag on the newborn on wrist or ankle (mother name, hospital no, sex, weight of newborn).
8. Give eye care to the newborn.
9. Check the reflexes present in the newborn.
10. Assess for any gross abnormality, congenital defects in head, eyes, ears, chest, spine,. face, nose, abdomen, anus, external genitalia & extremities.
11. Administer Inj. Vitamin K (I. M)

12.Wrape the baby & give to mother.
13.Assist mother to breast feed if she desire.
14.Complete charting, reporting &recording
15.Replace equipment after use & care for it.
16.Wash hands.

PROCEDURE 7: Apgar scoring

APGAR Scoring

Mother name: **Date of Delivery:**

Time of delivery: **Sex of baby:**

Procedure Steps	Zero	1	2	1min	5min
1. Respiratory effort	Absent	Slow irregular	Good cry		
2. Heart Rate	Absent	Below 100 B/M	Over 100 B/M		
3. Muscle tone	Flaccid	Some flexion of limbs	Well flexed		
4. Reflex	No response	Grimace	Cough or sneeze		
5. Colour	Blue or pale	Body pink, limbs blue	All pink		
Total					

Apgar Score Risk:		
1-4	H.R	High Risk.
5-7	M.R	Moderate Risk.
7-8	S.R	Small Risk.
10	Normal	

Unit – 3

Procedures done during postpartum period

Procedure 1: Assessment of uterine fundus postpartum

Procedure 2: Breast examination

Procedure 3: Breast care

Procedure 4: Perineal examination

Procedure 5: Perineal care

Procedure 6: Umbilical cord care

PROCEDURE 1: Assessment of uterine fundus postpartum

Purpose

1. To assess the level of uterine fundus.
2. To determine firmness of the uterus.
3. To promote contractility of the uterus.
4. To assess lochial characteristics.
5. To minimize the post partum bleeding.
6. To prevent health hazards which mother may be exposed.
7. To detect, diagnoses & provide management of any abnormality as early as possible.

Explain procedure to the woman & maintain privacy.
Ensure woman's bladder is empty.
Assemble equipment's:

- Clean & Sterile gloves
- Screen
- Antiseptic solution (Dettol / savlon)
- Sterile pad

Assist woman into supine position.
Assist the woman to relax by encouraging her to breathe naturally

Procedure

1. Gently place one hand on the lower segment of the uterus. Using the side of the other hand, palpate the abdomen until you locate the top of the fundus.
2. Determine whether the fundus is firm. If it is, it will feel like a hard round object in the abdomen. If it is not firm, massage the abdomen lightly until the fundus is firm.
3. Measure the top of the fundus in fingerbreadths above, below or at the fundus.
4. Determine the position of the fundus in relation to the midline of the body. If it is not in the midline, locate it and then evaluate the bladder for distention.
5. If the bladder is distended, use nursing measures to help the woman void.
6. Measure urine output for the next few hours until elimination is established.
7. Assess the lochia.
8. Remove bloody pads, clean perineum & pads, clean perineum & apply sterile perineal pad.
9. Record consistency & location of the fundus, bleeding & perineum.
10. Report a fundus that does not stay firm.
11. Make the woman comfortable and wash hands.

Procedure 2: Breast Examination

Purpose

1. To detect abnormalities in breast.
2. To teach a women how to perform breast self-examination.

Preparation

1. Assess

- The breast tissues for lump and cysts that may be require further medical evaluation
- Breast size ,shape and symmetry
- The elasticity of breast tissues
- Examination of the areola and nipple
- The nipple is assessed for evidence of blister ,cracks or fissures
- The nipple is also assessed for its type and size

Procedure

1. Prepare equipment
2. Welcome the woman
3. Put the mother in a sitting position.
4. Palpate the supra clavicle area.
5. Palpate axillary's nodes: hold women's forearm in your left palm while you check nodes with your right fingertips rotate in the other side.
6. Instruct woman to lie down with her right arm under her head and place a small pillow under her right shoulder.
7. With the flatten surface of 2 or 3 fingers gently palpate breast tissue beginning at the upper outer quadrant.
8. Repeat procedure for other breast.
9. Check the areola area for crustiness, nipple, and discharge signs of infection.
10. Record finding and report abnormalities to the physician.
11. Instruct the mother to perform breast self-examination and encourage her to ask any questions

Procedure 3: Breast Care

Purpose

1. To clean the Breast.
2. To prevent the cracked nipples.
3. To encourage milk flow.

Assess

- The breast tissues for lump and cysts that may be require further medical evaluation
- Breast size ,shape and symmetry
- The elasticity of breast tissues
- Examination of the areola and nipple
- The nipple is assessed for evidence of blister ,cracks or fissures
- The nipple is also assessed for its type and size

Equipment

- Macintosh
- Water & soap
- Disposable Gloves
- Cotton & gauze
- Paper bag

Procedure steps

1. Prepare equipments in suitable bed side table.
2. Wash hands with water & soap
3. Keep privacy of mother
4. Put the mother in a sitting position.
5. Expose the Mother's Breast and place Macintosh Under breast.
6. Inspect and palpate the Breast and nipple.
7. Massage the Breast from up to down toward the areola and nipple.
8. Express few drops of colostrum or Milk from the Breast.
9. Clean the Breast by warm water beginning with nipple and areola and going outward in a circular motion.
10. Dry the breast and apply a piece of gauze on the nipple and areola.
11. Clean the other breast in the similar manner.
12. In case of breast engorgement ask mother to wear suitable bra and express the milk out as much as possible.
13. Discard wastes in paper bag.
14. Cover the mother's Breast.
15. Instruct mother about importance of Breast care and Breast feeding.
16. Record observations.

Procedure 4: Perineal examination

Purpose :

1. To observe perineal trauma & the state of healing.
2. To detect any abnormality as early as possible.
3. To prevent health hazards which mother may be exposed?

1. Explain procedure to the woman & maintain privacy.
2. Ensure woman's bladder is empty.
3. Assemble equipments:
    a. Screen.
    b. Sterile gloves
    c. Macintosh
    d. Flash light.
4. Request the mother to assume a Sims position & flex her upper leg & expose /; perineum.

Procedure

1. Wash hands and wear gloves.
2. Place macintosh under mother's hips.
3. Lower the perineal pad & lift the superior buttocks.
4. Use a flashlight.
5. Note the extent & location of edema or bruising.
6. Examine the episiotomy or laceration for (REEDA) Redness, Ecchymosis, Edema, Discharge & Approximation.
7. Note number & size of hemorrhoids.
8. Instruct mother to turn on back & cover her.
9. Remove the equipments & wash hands.
10. Report any abnormalities.

Procedure 5: Perineal care

Purpose:

- To maintain cleanliness and comfort.
- To promote healing of suture line.
- To instruct the mother about perineal self-care.

1. Explain procedure to the woman & maintain privacy.
2. Ensure woman's bladder is empty.
3. Assemble equipments:
    a. Sterile gloves.
    b. Macintosh
    c. Paper bag.
    d. Sterile Perineal Pad.
    e. Dressing set
    f. Sterile cotton swabs in bowl
    g. Antiseptic solution
    h. Bedpan (if required)
4. Position the mother in dorsal recumbent position.

Procedure

1. Wash hands and wear gloves.
2. Place macintosh under mother's hips.
3. Remove soiled pad from front to back.
4. Observe color, amount and odor.
5. Wrap soiled pad &throw it in paper bag.
6. Test the temperature of the antiseptic solution and pour over vulva.
7. Use dressing set & swabs for cleaning according to the following direction:
8. Mons pubis from the level of clitoris upward to the lower abdomen in a zigzag line.
9. Both thighs from medial to lateral in a zigzag line.
10. Labia majora (both side) from upward to downward in a single motion.
11. Labia minora (both side) from upward to downward in a single motion.
12. The introitus from upward to downward in a single motion.
13. Anus downward in a single motion.
14. Dry the perineum using the same technique and put sterile perineal pad from up to down without touching the surface close to the woman.
15. Rearrange bed, clothes & make the women comfort.
16. Remove screen & equipment from bed side and wash hands.
17. Record and report the date & time of procedure, discharge, genitalia condition and any abnormalities.

Procedure 6: Umbilical Cord Care

Purpose

- To ensure complete and proper healing of the umbilical cord of the newborn.
- To observe abnormalities of the cord such as bleeding, infection, hernia and abnormalities in vein and arteries .
- To prevent infection

Equipment

- Sterile cotton sponges
- Sterile forceps and\or gloves
- Ordered medicine if required
- Paper bag or kidney basin

1. Prepare equipment
2. Explain the procedure to the mother
3. Prepare environment (tidy, clean, avoid air draft)
4. Prepare baby
5. Hold the umbilical cord away from the skin with one hand
6. Wipe the stump and the area around the umbilicus by the other hand ,using an antiseptic solution if required.
7. If the cord drops off, wipe the granulating area (Stump) using antiseptic.
8. Dry the area carefully
9. Observe the cord for
    a. -Signs of bleeding
    b. -Signs of infection
    c. -Any other abnormality as hernia
    d. -Abnormalities in the vein and arteries.

Procedure : The first physical Examination during pregnancy						
		Performed		Mastered	Comments
Preparation		Yes	No		
1.	**Equipment** • Stethoscope • Light measuring device • Thermometer • Sphygmomanometer • Tongue depressor • Weighing scale • Urine testing facility • Client record				
Procedure					
1.	Prepare equipment				
2.	Welcome the woman				
3.	Instruct her to evacuate the bladder and collect a midstream specimen of urine				
4-	Test urine for sugar ,protein and Ketone				
5-	Measure accurately woman's weight without shoes				
6-	Measure accurately woman's height without shoes				
7-	Measure correctly her blood pressure				
8-	Measure correctly her pulse				
9-	Please the woman on the examination couch on her back				
10-	Explain the procedure to her				
11-	Drape the woman and keep the doors and curtains closed				
12-	Wash your hand				
13-	Stand at the right side of the woman				
14-	Examine the head .				
	• Check hair for lice and nits • Check the face for pallor ,edema and facial expression • Check conjunctiva for degree of redness • Note any pigmentation on forehead and cheeks • Examine mouth for condition of gums and teeth				
15-	Examine the neck :				

	Palpate the nodes below the posterior angle of the jawbone				
	Check the neck for the thyroid gland				
16-	Examination the chest				
	Assist with examination of the heart and lung by preparing the woman				
	Examination the breast ,nipple and areola				
17-	Examine the abdomen				
18-	Examine the extremities				
	Check the color of the palms and nails				
	Check swelling of fingers				
	Examine the legs ,ankles and feet for shape and unequal length				
	Check edema over the tibia,ankle and feet				
	Observe legs for dilated veins				
19-	Assist with pelvic examination				
20-	Check the woman for danger signs of pregnancy				
21-	Assist the woman to get down from examination table and redress her clothes				
22-.	Record findings and woman's reaction				
23-	Replace equipment's				
24-	Wash hands				
25-	Give the woman the necessary instruction and date of the next visit				
26-	Refer abnormal case				

Procedure : Abdominal Examination					
		Performed		**Mastered**	**Comments**
Preparation		**Yes**	**No**		
1.	**Equipment** • Tap measure • Pinard fetoscope or sonic fetal heart sound device • Client record				
Procedure					
1.	Prepare equipment				
2.	Welcome the woman				
3.	Preparing mother				
4-	Instruct her to evacuate the bladder				
5-	Positioning mother on her back on a firm bed or examination table				
6-	Standing at the side of bed, facing the mother during the first three maneuver but in the last one the nurse reverses her position and faces her feet.				
7-	**First Maneuver**				
	• Ascertaining the fundus and determined its level Gently palpate the fundus with the tips of the Fingers of both hands in oreder to define which fetal part is present in the fundus				
8-	**Second Maneuver**				
	Applying the palm of the hands on either side of the mother abdomen gentle but deep pressure is exerted to locate the back of the fetus in relation to the right and left sides of the mother.				
9-.	**Third Maneuver**				
	Employing the thumb and fingers grasping the lower portion of the maternal abdomen, just above symphasis pubis to determine if the presenting part is engaged or not				
10-	**Fourth Maneuver**				
	- Facing the mother's feet, using the tips of the first three fingers of each hand, making deep pressure in the direction of the axis of the pelvic inlet to ascertain presenting part of the engaged head. - Identifying the fetal position correctly. - identifying which best place to hear the fetal heart tone. - Hearing the fetal heart tone and count.				

11-.	*** Auscultation**				
	- Place the pinard fetal stethoscope at right angles about 5 cm above the head on the side of abdomen where the back was felt, keep the ear in firm contact with the pinard, don't touch it while listening. Listen carefully and count for 60 seconds.				

Procedure : Testing Urine for protein &Sugar using urinary dipstick					
		Performed		Mastered	Comments
Preparation		Yes	No		
1.	**Equipment** • Clinistix reagent strips • Gloves • Special container for collecting urine				
Procedure					
1.	Prepare equipment				
2.	Welcome the woman				
3.	Explain the procedure to her				
4.	Instruct her to evacuate the bladder and collect a midstream specimen of urine in Special container				
5-	Dip a dipstick in the urine and compare the test result color with the color comparison chart provided on the reagent strip bottle.				
6-	Remove gloves				
7-	Wash hands				
8-	Record test time and finding				
9-	Interpret test outcomes and explain it to the woman				

PROCEDURE 1.4: Assessing pitting edema

OBSERVATION CHECKLIST

Procedure : Assessing pitting edema					
		Performed		**Mastered**	**Comments**
	Procedure	**Yes**	**No**		
1.	Explain the procedure & its purpose to the mother.				
2.	Screen the mother's bed.				
3-	Ask the women & family members if the women's face or hands appear swollen.				
4-	Inspect the women's face, extremities and sacral area for signs of pitting edema				
5-	Press each area firmly with thumb or index finger for several seconds & release.				
6-	Evaluate the Extensiveness of edema, Depth of depression & Length of time it takes to clear.				
7-	Grade the pitting edema according to the following scale 1+ =minimal edema of lower extremities 2+ =marked edema of lower extremities 3+ =edema of the lower extremities, face & hands 4+ =generalized, massive edema				
8-	Record your findings & compare your findings with those previously recorded				

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
1.	Explain procedure to the woman.			
2.	Ensure woman's bladder is empty.			
3.	Assemble equipments: • Screen • Wrist watch • Stethoscope / Doppler			
4.	Put the mother in dorsal recumbent position & screen the mother bed.			
	Procedure			
5.	Assist the woman to relax by encouraging her to breathe naturally & to take deep breaths during contractions.			
6.	Place fingertips of one hand on uterus, keep fingertips relatively still rather than moving them over uterus.			
7.	Note time when each contraction begins & ends to determine- Frequency by calculation average time that elapses from beginning of one contraction until beginning of next one Duration by noting average time in seconds from beginning to end of each contraction. Interval by noting average time between end of one contraction & beginning of the next one.			
8.	Auscultate fetal heart rate after each contraction reading.			
9.	Monitor the vital signs for the woman.			
10.	Observe the woman for any abnormal uterine contractions and fetal heart rate.			
11.	Wash hands and document the finding.			

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
	Explain procedure to the woman.			
	Ensure woman's bladder is empty.			
	Assemble equipments: • Doppler device • Ultrasonic gel			
	uncover the women's abdomen			
	Procedure			
	Place the ultrasonic gel on the diaphragm of the Doppler.			
	Place the Doppler diaphragm on the woman’s abdomen halfway between the umbilicus and symphysis and in the midline.			
	Check the woman’s pulse against the fetal sounds you hear. If the rates are the same, reposition the Doppler.			
	If the rates are not similar, count the FHR for 1 full minute.			
	Auscultate the FHR between, during and for 30 seconds following a uterine contraction.			
10	Document the fetal heart rate count.			

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
1.	Explain procedure to the woman & maintain privacy.			
2.	Ensure woman's bladder is empty.			
3.	Assemble equipments: • Sterile gloves • Screen • Lubricating jelly • Antiseptic solution (Dettol / savlon) • Sterile pad			
4.	Assist woman into supine position on exam table with lower extremities flexed and rotated outward, her heels should be supported in stirrup which are level with the table about 1 - 2 Ft in front of her buttocks [Lithotomy position].			
5.	Assist the woman to relax by encouraging her to breathe naturally.			
	Procedure			
	Expose the perineal area for examination.			
	Prepare the area with antiseptic solution.			
6.	Put on gloves, from standing position using thumb & fore finger of non-dominant hand to spread the labia.			
7.	Insert the well lubricated index & middle fingers of dominant hand into the vagina until they touch the cervix, using downward & upward direction and keep thumb of dominant hand upward and supported on vulva.			
	Note presentation, position of fetus, cervical dilatation& effacement, station of fetal head, status of membranes.			
8.	Provide care with antiseptic solution & put on sterile pad after care.			
9.	Remove the equipment & gloves.			
10.	Wash hands and document the finding.			

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
1.	Explain procedure to the woman.			
2.	Assemble equipments: • Monitor • Two elastic monitor belts • Tocodynamometer • Ultrasound transducer • Ultrasonic gel			
	Procedure			
3.	Turn on the monitor.			
4.	Place the two elastic belts around the woman's abdomen.			
5.	Place the tocodynamometer over the uterine fundus off the midline on the area palpated to be most firm during contractions. Secure it with one of the elastic belts.			
6.	Note the uterine contraction tracing. The resting tone tracing should be recording on the 10 or 15 mm Hg pressure line.			
7.	Apply the ultrasonic gel to the diaphragm of the ultrasound transducer.			
8.	Place the diaphragm on the maternal abdomen in the midline between the umbilicus and the symphysis pubis.			
9.	Listen for the FHR.			
10.	When the FHR is located, attach the second elastic belt snugly to the transducer.			
11.	Place the following information on the beginning of the fetal monitor paper: date, time, woman's name, gravida, para, membrane status and name of doctor & nurse- midwife.			
12.	Document about maternal and fetal condition.			

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
1.	Explain procedure to the woman & maintain privacy.			
2.	Check good place, light & complete equipment.			
3.	Assemble equipments: • 2 gowns, 2 gloves, 2 masks. • 5 towels. • Dressing & tissue gauze. • Foley's Catheter. • Sterile pads • Antiseptic solution • Syringes; one for local anesthesia & one for methergine. • Instruments; 2 kochers, 2 artery forceps, 2 scissors, 1 needle holder, 1 tissue forceps, toothed & non-toothed, cutting & round needle. • Chromic catgut suture. • Newborn tray; cord clamp, identification band, suction tube, alcohol swab, scissor, eye drop, towel.			
4.	Put mother in lithotomy position.			
5.	Monitor progress of labor (maternal & fetal condition) and identify signs of 2nd stage of labor.			
	Procedure			
6.	Put on mask, overhead & scrubbing, gowning & gloving.			
7.	Expose the perineal area for examination.			
	Prepare the area with antiseptic solution.			
8.	Drape the mother.			
9.	Evacuate mother's bladder by catheterization.			
10.	Perform P/V examination to know the progress of labor.			
11.	Instruct mother to bear down during contraction & relax in-between.			
12.	Prepare the syringe for local anesthesia.			
13.	Observe presenting part for crowning occur.			
14.	When 3 - 4 cm of the head appears during uterine contraction perform right mediolateral episiotomy.			
15.	Support perineum with sterile dressing & maintain good flexion of the fetal head at the same time.			
16.	Deliver head & expulsion of fetal body.			
17.	Clamp and cut the umbilical cord at least one minute after birth: clamp the umbilical cord at about 3 cm from the baby's umbilicus and apply a second clamp at 2 cm distally to the first one. Lift the clamped cord and cut it in between the two clamps.			

18.	Show the baby to mother and hand over the newborn to other staff to give immediate care of newborn.			
19.	Observe the woman for signs of placental separation.			
20.	Wait for spontaneous expulsion of placenta otherwise deliver the placenta by controlled cord traction method.			
21.	Administer inj. Methargin following the delivery of placenta.			
22.	Perform examination of placenta & its membranes for completeness & any abnormalities.			
23.	Perform fundal massage to make it firm and remove the clots coming from uterus.			
24.	Give perineal care & change the towel under the mother.			
25.	Ensure the uterus is well contracted.			
26.	Observe episiotomy site for bleeders and repair episiotomy in three layers.			
27.	Provide perineal care with antiseptic swabs and put sterile pad.			
28.	Remove all towels and clean the mother.			
29.	Instruct the mother to lie supine with legs crossed.			
30.	Observe the woman for any complications like PPH, shock.			
31.	Collect equipment & clean instrument.			
32.	Wash hands & send the delivery sets to sterilization.			
33.	Report and record the procedure & condition of mother & baby.			

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
1.	Keep the room warm.			
2.	Assemble equipments: • Vaccum suction, sterile catheter & oxygen. • Cord ligature or clamp. • Sterile scissor & artery. • Warm sterile towel. • Rectal thermometer • Cotton balls. • Bath of water at 37 ^{0}C • Alcohol 70%. • Gauze • Birth record • Eye drop.			
3.	Wash hands and wear gloves.			
4.	Put the newborn under radiant warmer in side lying or trendlenburng position to prevent aspiration of secretions.			
	Procedure			
5.	Dry the baby thoroughly and remove the wet linen.			
6.	If needed suction the mouth first and then the nose gently.			
7.	Use sterile plastic clamp or ligature, the first ligature is placed about 2 inch from the abdomen & second ligature is placed about 1 cm from the first ligature. Cut the cord by blunt sterile scissor after the second knot. Examine umbilical cord structure.			
8.	Complete **1** minute & **5** minute Apgar score.			
9.	Measure vital signs pulse, respiration & temperature.			
10.	Measure length, weight, head circumference, chest circumference & abdominal circumference.			
11.	Place Identification tag on the newborn on wrist or ankle (mother name, hospital no, sex, weight of newborn).			
12.	Give eye care to the newborn.			
13.	Check the reflexes present in the newborn.			
14.	Assess for any gross abnormality, congenital defects in head, eyes, ears, chest, spine,. face, nose, abdomen, anus, external genitalia & extremities.			
15.	Administer Inj. Vitamin K (I. M)			
16.	Wrape the baby & give to mother.			
17.	Assist mother to breast feed if she desire.			
18.	Complete charting, reporting &recording			
19.	Replace equipment after use & care for it.			
20.	Wash hands.			

APGAR Scoring

Mother name: **Date of Delivery:**

Time of delivery: **Sex of baby:**

Procedure Steps	**Zero**	**1**	**2**	**1min**	**5min**
1. Respiratory effort	Absent	Slow irregular	Good cry		
2. Heart Rate	Absent	Below 100 B/M	Over 100 B/M		
3. Muscle tone	Flaccid	Some flexion of limbs	Well flexed		
4. Reflex	No response	Grimace	Cough or sneeze		
5. Colour	Blue or pale	Body pink, limbs blue	All pink		
Total					

Apgar Score Risk:		
1-4	H.R	High Risk.
5-7	M.R	Moderate Risk.
7-8	S.R	Small Risk.
10	Normal	

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
1.	Explain procedure to the woman & maintain privacy.			
2.	Ensure woman's bladder is empty.			
3.	Assemble equipments: • Clean & Sterile gloves • Screen • Antiseptic solution (Dettol / savlon) • Sterile pad			
4.	Assist woman into supine position.			
5.	Assist the woman to relax by encouraging her to breathe naturally.			
	Procedure			
6.	Gently place one hand on the lower segment of the uterus. Using the side of the other hand, palpate the abdomen until you locate the top of the fundus.			
7.	Determine whether the fundus is firm. If it is, it will feel like a hard round object in the abdomen. If it is not firm, massage the abdomen lightly until the fundus is firm.			
8.	Measure the top of the fundus in fingerbreadths above, below or at the fundus.			
9.	Determine the position of the fundus in relation to the midline of the body. If it is not in the midline, locate it and then evaluate the bladder for distention.			
10.	If the bladder is distended, use nursing measures to help the woman void.			
11.	Measure urine output for the next few hours until elimination is established.			
12.	Assess the lochia.			
13.	Remove bloody pads, clean perineum & pads, clean perineum & apply sterile perineal pad.			
14.	Record consistency & location of the fundus, bleeding & perineum.			
15.	Report a fundus that does not stay firm.			
16.	Make the woman comfortable and wash hands.			

Procedure **Breast examination**					
		Performed		Mastered	Comments
	Preparation	Yes	No		
1.	**Assess** • The breast tissues for lump and cysts that may be require further medical evaluation • Breast size ,shape and symmetry • The elasticity of breast tissues • Examination of the areola and nipple • The nipple is assessed for evidence of blister ,cracks or fissures • The nipple is also assessed for its type and size				
	Procedure				
1.	Prepare equipment				
2.	Welcome the woman				
3.	Put the mother in a sitting position.				
4-	Palpate the supra clavicle area.				
5-	Palpate axillary's nodes: hold women's forearm in your left palm while you check nodes with your right fingertips rotate in the other side.				
6-	Instruct woman to lie down with her right arm under her head and place a small pillow under her right shoulder.				
7-	With the flatten surface of 2 or 3 fingers gently palpate breast tissue beginning at the upper outer quadrant.				
8-	Repeat procedure for other breast.				
9-	Check the areola area for crustiness, nipple, and discharge signs of infection.				
10-	Record finding and report abnormalities to the physician.				
11-	Instruct the mother to perform breast self-examination and encourage her to ask any questions				

		Performed		Comments
	Preparation	Yes	No	
1.	**Assess** • The breast tissues for lump and cysts that may be require further medical evaluation • Breast size ,shape and symmetry • The elasticity of breast tissues • Examination of the areola and nipple			

	• The nipple is assessed for evidence of blister ,cracks or fissures • The nipple is also assessed for its type and size			
	Equipment • Macintosh • Water & soap • Disposable Gloves • Cotton &gauze			
Procedure				
1.	Prepare equipments in suitable bed side table.			
2.	Wash hands with water & soap			
3-	Keep privacy of mother			
4-	Put the mother in a sitting position.			
5-	Expose the Mother's Breast and place Macintosh Under breast.			
6-	Inspect and palpate the Breast and nipple.			
7-	Massage the Breast from up to down toward the areola and nipple.			
8-	Express few drops of colostrum or Milk from the Breast.			
9-	Clean the Breast by warm water beginning with nipple and areola and going outward in a circular motion.			
10-	Dry the breast and apply a piece of gauze on the nipple and areola.			
11-	Clean the other breast in the similar manner.			
12-	In case of breast engorgement ask mother to wear suitable bra and express the milk out as much as possible.			
13-	Discard paper bag with wastes.			
14	Cover the mother's Breast.			
15	Instruct mother about importance of Breast care and Breast feeding.			
16	Record observations.			

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
1.	Explain procedure to the woman & maintain privacy.			
2.	Ensure woman's bladder is empty.			
3.	Assemble equipments: • Screen. • Sterile gloves • Macintosh • Flash light.			
4.	Request the mother to assume a Sims position & flex her upper leg & expose perineum.			
	Procedure			
5.	Wash hands and wear gloves.			
6.	Place macintosh under mother's hips.			
7.	Lower the perineal pad & lift the superior buttocks.			
	Use a flashlight.			
8.	Note the extent & location of edema or bruising.			
9.	Examine the episiotomy or laceration for (REEDA) Redness, Ecchymosis, Edema, Discharge & Approximation.			
10.	Note number & size of hemorrhoids.			
11.	Instruct mother to turn on back & cover her.			
12.	Remove the equipments & wash hands.			
13.	Report any abnormalities.			

S. NO.	STEPS	Performance		Remarks
	Preparation of patient & equipments	**Done**	**Not done**	
1.	Explain procedure to the woman & maintain privacy.			
2.	Ensure woman's bladder is empty.			
3.	Assemble equipments: • Sterile gloves. • Macintosh • Paper bag. • Sterile Perineal Pad. • Dressing set • Sterile cotton swabs in bowl • Antiseptic solution • Bedpan (if required)			
4.	Position the mother in dorsal recumbent position.			
	Procedure			
5.	Wash hands and wear gloves.			
6.	Place macintosh under mother's hips.			
7.	Remove soiled pad from front to back.			
8.	Observe color, amount and odor.			
9.	Wrap soiled pad &throw it in paper bag.			
10.	Test the temperature of the antiseptic solution and pour over vulva.			
11.	Use dressing set & swabs for cleaning according to the following direction: ✓ Mons pubis from the level of clitoris upward to the lower abdomen in a zigzag line. ✓ Both thighs from medial to lateral in a zigzag line. ✓ Labia majora (both side) from upward to downward in a single motion. ✓ Labia minora (both side) from upward to downward in a single motion. ✓ The introitus from upward to downward in a single motion. ✓ Anus downward in a single motion.			
12.	Dry the perineum using the same technique and put sterile perineal pad from up to down without touching the surface close to the woman.			
13.	Rearrange bed, clothes & make the women comfort.			
14.	Remove screen & equipment from bed side and wash hands.			
15.	Record and report the date & time of procedure, discharge, genitalia condition and any abnormalities.			

Procedure : Umbilical cord care					
		Performed		Mastered	Comments
Preparation		Yes	No		
1.	**Equipment** • 2Sterile small iodine • Sterile cotton sponges • Antiseptic solution ,alcohol 60% • Sterile forceps and\or gloves • Ordered medicine if required • Paper bag or kidney basin				
Procedure					
1.	Prepare equipment				
2.	Explain the procedure to the mother				
3.	Prepare environment (tidy, clean, avoid air draft)				
4-	Prepare baby				
5-	Hold the umbilical cord away from the skin with one hand				
6-	Wipe the stump and the area around the umbilicus by the other hand ,using an antiseptic solution ,alcohol 60%				
7-	If the cord drops off, wipe the granulating area (Stump) using antiseptic.				
8-	Dry the area carefully				
9-	Observe the cord for -Signs of bleeding -Signs of infection -Any other abnormality as hernia -Abnormalities in the vein and arteries.				