كلية العلوم الطبية التطبيقية
College of Applied Medical Sciences

المملكة العربية السعودية
وزارة التعليم
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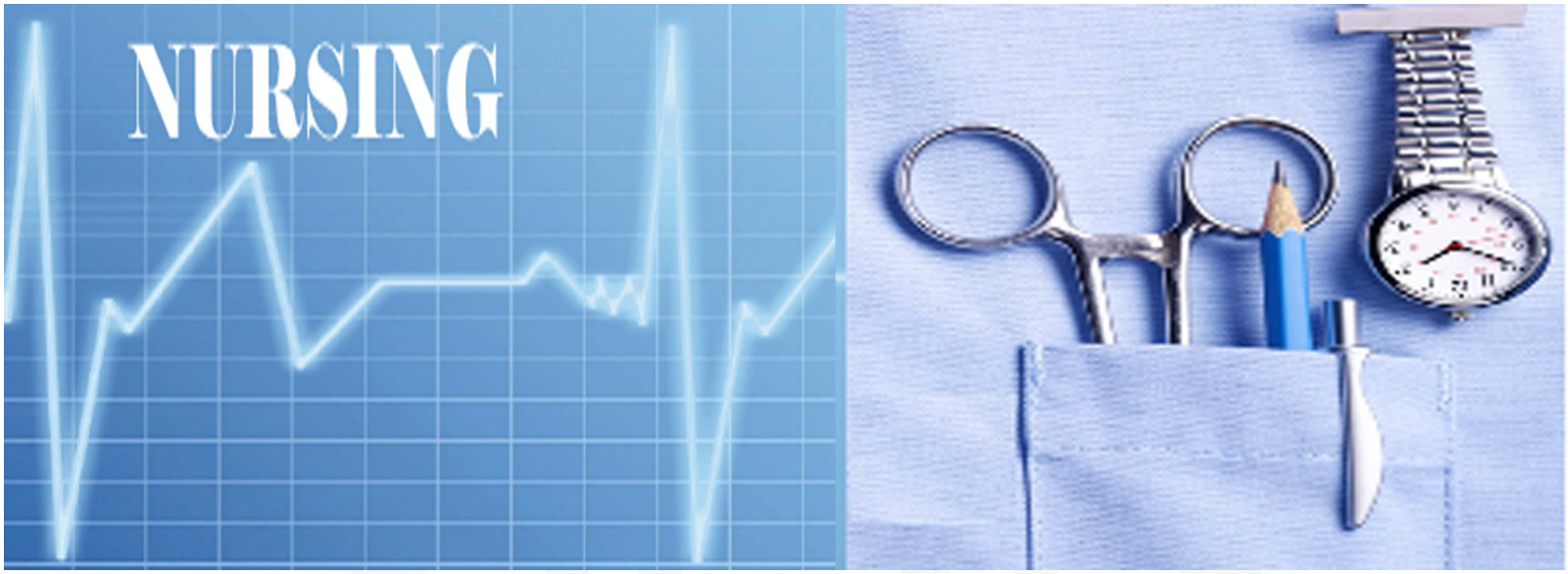

Skills Laboratory Manual in

MATERNAL-NEWBORN HEALTH NURSING

(NRS 362)

Document Revision Control History

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CHAPTER (1)

PROCEDURES DONE DURING ANTEPARTUM PERIOD

PROCEDURE 1.1: Perform first physical examination during pregnancy.

PROCEDURE 1.2: Perform abdominal examination during pregnancy using Leopold maneuvers.

PROCEDURE 1.3: Testing urine for protein & sugar using urinary dipstick.

PROCEDURE 1.4: Assessing pitting edema.

ROCEDURE 1.1: Perform first physical examination during pregnancy

Objectives:

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

Equipment

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

Procedure

1. Prepare equipments.
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 and height without shoes.
6. Measure correctly her blood pressure and pulse.
7. Place the woman on the examination couch on her back.
8. Explain the procedure to her.

9. Drape the woman and keep the doors and curtains closed.

10. Wash your hand.

11. Stand at the right side of the woman.

12. Examine the head:

a. Check hair for lice and nits

b. Check the face for pallor ,edema and facial expression

c. Check conjunctiva for degree of redness

d. Note any pigmentation on forehead and cheeks

e. Examine mouth for condition of gums and teeth

13. Examine the neck for lymph nodes.

14. Examination of the chest: Assist with examination of the heart and lung by preparing the woman.

15. Examination of the breast, nipple and areola for size, shape, lumps & discharge.

16. Examine the abdomen for shape, masses, contour.

17. Examine the extremities for color of the palms and nails and swellings.

18. Examine the legs, ankles and feet for shape and unequal length. Check edema over the tibia, ankle and feet. Observe legs for varicosities.

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 1.2: Perform abdominal examination during pregnancy using Leopold maneuvers

Objectives:

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

Equipment

- Tap measure
- Pinard fetoscope or doppler
- Client record

Procedure

1. Prepare equipment
2. Welcome the woman.
3. Explain the procedure to her.
4. Collect complete history from mother including obstetrical & menstrual history.
5. Instruct her to evacuate the bladder
6. Positioning mother on her back on a firm bed or examination table .
7. Standing at the right 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.
8. Measure abdominal girth, fundal height in weeks & cms.
9. Inspection: Observe skin changes on abdomen.

10. Palpation:

a. 1st Maneuver: Ascertaining the fundus and determined its level Gently palpate the fundus with the tips of the Fingers of both hands in order to define which fetal part is present in the fundus

b. 2nd 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.

c. 3rd 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.

d. 4th 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.

11. Auscultation: Place the pinard fetoscope or Doppler 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.

12. Make the woman comfortable.

13. Replace the equipments.

14. Wash hands.

15. Document the findings.

PROCEDURE 1.3: 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.

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

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
    a. 1+ =minimal edema of lower extremities
    b. 2+ =marked edema of lower extremities
    c. 3+ =edema of the lower extremities, face & hands
    d. 4+ =generalized, massive edema
8. Record your findings & compare your findings with those previously recorded

CHAPTER (2)

PROCEDURES DONE DURING INTRAPARTUM PERIOD

PROCEDURE 2.1: Monitoring women during 1st stage of labor using partograph (Assessment of Uterine Contractions).

PROCEDURE 2.2: Vaginal examination during labor .

PROCEDURE 2.3: External electronic fetal monitoring .

PROCEDURE 2.4: Monitoring woman during labor (2nd and 3rd stages of labor).

PROCEDURE 2.5: Immediate newborn Care .

PROCEDURE 2.1: 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 woman & equipments:

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.
5. Assist the woman to relax by encouraging her to breathe naturally & to take deep breaths during contractions.

Procedure:

1. Place fingertips of one hand on uterus, keep fingertips relatively still rather than moving them over uterus.
2. Note time when each contraction begins & ends to determine-
   a. Frequency by calculation average time that elapses from beginning of one contraction until beginning of next one
   b. Duration by noting average time in seconds from beginning to end of each contraction.
   c. Interval by noting average time between end of one contraction & beginning of the next one.

3. Auscultate fetal heart rate after each contraction reading.
4. Monitor the vital signs for the woman.
5. Observe the woman for any abnormal uterine contractions and fetal heart rate.
6. Wash hands and document the finding.

PROCEDURE 2.2: 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 woman & equipments:

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:

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 and 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 2.3: External electronic fetal monitoring

Objectives:

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

Preparation of woman & equipment:

1. Explain procedure to the woman.
2. Assemble equipment:
    - 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 2.4: Assisting woman in active management of 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 assist doctor in labor procedure.
5. To detect & provide proper management of any hazards as early as possible.

Preparation of woman & equipments:

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:

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 & deliver head of the baby.
12. Check for cord around the neck. If present:
    a. Loose around the neck: slip over the head & deliver the fetal body.
    b. Tight around the neck: clamp the cord with two artery forceps, cut with scissor & remove the cord around the neck & deliver the fetal body.
13. Note the time of birth.
14. 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.
15. Show the baby to mother and hand over the newborn to other staff to give immediate care of newborn.
16. Observe the woman for signs of placental separation.
17. Wait for spontaneous expulsion of placenta otherwise deliver the placenta by controlled cord traction method.
18. Administer inj. Methargin following the delivery of placenta.
19. Perform examination of placenta & its membranes for completeness & any abnormalities.
20. Perform fundal massage to make it firm and remove the clots coming from uterus.
21. Give perineal care & change the towel under the mother.

22. Ensure the uterus is well contracted.
23. Observe episiotomy site for bleeders and repair episiotomy in three layers.
24. Provide perineal care with antiseptic swabs and put sterile pad.
25. Remove all towels and clean the mother.
26. Instruct the mother to lie supine with legs crossed.
27. Observe the woman for any complications like PPH, shock.
28. Collect equipment & clean instrument.
29. Wash hands & send the delivery sets to sterilization.
30. Report and record the procedure & condition of mother & baby.

PROCEDURE 2.5: Immediate newborn Care

Objectives:

1. To ensure an open air way & 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.

Preparation of room & equipments:

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
    - Gauze
    - Birth record
    - Eye drop.
3. Wash hands and wear gloves.

Procedure:

1. Put the newborn under radiant warmer in side lying or trendlenburg position to prevent aspiration of secretions.
2. Dry the baby thoroughly and remove the wet linen.
3. If needed suction the mouth first and then the nose gently.
4. 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.
5. Complete **1** minute & **5** minute Apgar score.
6. Measure vital signs pulse, respiration & temperature.
7. Measure length, weight, head circumference, chest circumference & abdominal circumference.
8. Place Identification tag on the newborn on wrist or ankle (mother name, hospital no, sex, weight of newborn).
9. Give eye care to the newborn.
10. Check the reflexes present in the newborn.
11. Assess for any gross abnormality, congenital defects in head, eyes, ears, chest, spine,. face, nose, abdomen, anus, external genitalia & extremities.
12. Administer Inj. Vitamin K (I. M)
13. Wrape the baby & give to mother.
14. Advice the mother to breast feed.
15. Complete charting, reporting &recording
16. Replace equipment after use & care for it.
17. Wash hands.

CHAPTER (3)

PROCEDURES DONE DURING POSTPARTUM PERIOD

PROCEDURE 3.1: Assessment of uterine fundus postpartum

PROCEDURE 3.2: Breast examination

PROCEDURE 3.3: Breast care

PROCEDURE 3.4: Perineal examination

PROCEDURE 3.5: Perineal care

PROCEDURE 3.1: Assessment of uterine fundus postpartum

Objectives:

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.

Preparation of woman & equipments:

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:

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 3.2: Breast examination

Objectives:

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

Preparation of woman & Equipments:

1. Assess the breast for size, shape, symmetry, elasticity, lumps & dimpling.
2. Assess the areola and nipple for its type, size, cracks & fissures.
3. Prepare equipment
   - Screen
   - Drape sheet
4. Welcome the woman
5. Put the mother in a sitting position.

Procedure:

6. Palpate the supra clavicle area for presence of lymph nodes.
7. 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.
8. Instruct woman to lie down with her right arm under her head and place a small pillow under her right shoulder.
9. With the flatten surface of 2 or 3 fingers gently palpate breast tissue beginning at the upper outer quadrant.
10. Check the areola area for crustiness, nipple, and discharge signs of infection.
11. Repeat procedure for other breast.
12. Instruct the mother to perform breast self-examination.
13. Document the findings.

PROCEDURE 3.3: Breast care

Objectives:

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

Preparation of woman & Equipments:

1. Assess the breast for size, shape, symmetry, elasticity, lumps & dimpling.
2. Assess the areola and nipple for its type, size, cracks & fissures.
3. Prepare equipment
    - Macintosh
    - Water
    - Disposable Gloves
    - Cotton &gauze
    - Screen
4. Maintain privacy.
5. Put the mother in a sitting position.

Procedure:

1. Wash hands with water & soap
2. Expose the Mother's Breast and place Macintosh Under breast.
3. Inspect and palpate the Breast and nipple.
4. Massage the Breast from up to down toward the areola and nipple.
5. Express few drops of colostrum or Milk from the Breast.

6. Clean the Breast by warm water beginning with nipple and areola and going outward in a circular motion.
7. Dry the breast and apply a piece of gauze on the nipple and areola.
8. Clean the other breast in the similar manner.
9. In case of breast engorgement ask mother to wear suitable bra and express the milk out as much as possible.
10. Discard paper bag with wastes.
11. Cover the mother's Breast.
12. Instruct mother about importance of Breast care and Breast feeding.
13. Document the findings.

PROCEDURE 3.4: Perineal examination

Objectives:

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?

Preparation of woman & equipments:

1. Explain procedure to the woman & maintain privacy.
2. Ensure woman's bladder is empty.
3. Assemble equipments:
    - Screen.
    - Sterile gloves
    - Macintosh
    - Flash light.

Procedure:

1. Request the mother to assume a Sims position & flex her upper leg & expose perineum.
2. Wash hands and wear gloves.
3. Place Macintosh under mother's hips.
4. Lower the perineal pad & lift the superior buttocks.
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. Document the findings.

PROCEDURE 3.5: Perineal care

Objectives:

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

Preparation of woman & equipments:

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:

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:
    - 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.
8. Dry the perineum using the same technique and put sterile perineal pad from up to down without touching the surface close to the woman.
9. Rearrange bed, clothes & make the women comfort.
10. Remove screen & equipment from bed side and wash hands.
11. Document the findings as the date & time of procedure, discharge, genitalia condition and any abnormalities.

CHAPTER (4)

PERFORMANCE CHECKLIST

- Perform abdominal examination during pregnancy using Leopold maneuvers
- Assessing pitting edema
- Assessment of Uterine Contractions (1st stage of labor)
- External electronic fetal monitoring
- Immediate newborn Care
- Assessment of uterine fundus postpartum
- Breast examination
- Breast care
- Perineal examination
- Perineal care

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Majmaah University

NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Perform abdominal examination during pregnancy using Leopold maneuvers

	Preparation	**Performed**		**CLO'S**
		Yes	**No**	
	Assemble Equipments Tape measure Pinardfetoscope or sonic fetal heart sound device Client record			
	Procedure			
1	Welcome the woman and explain procedure to her.			C1.1
2	Collect complete history from mother including obstetrical & menstrual history.			K1.1
3	Instruct her to evacuate the bladder.			S5.1
4	Positioning mother on her back on a firm bed or examination table.			S4.1
5	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.			S4.1
6	Measure abdominal girth, fundal height in weeks &cms.			S4.1
7	**Inspection:** Observe skin changes on abdomen.			S4.1
8	**Palpation:** 1ST MANEUVER: Ascertaining the fundus and determined its level. Gently palpate the fundus with the tips of the Fingers of both hands in order to define which fetal part is present in the fundus.			S4.1
9	2ND 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.			S4.1
10	3RD 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			S4.1

11	4TH 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.			S4.1
12	**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.			S4.1
13	Make the woman comfortable.			S5.1
14	Replace the equipments& wash hands.			S5.1
15	Document the findings in the record.			S5.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
K1.1 (1)	
S4.1 (9)	
S5.1 (4)	
C1.1 (1)	
TOTAL (15)	

NAME & SIGNATURE OF EVALUATOR:……

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NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Assessing pitting edema

		Performed		CLO'S
Procedure		**Yes**	**No**	
1.	Explain the procedure & its purpose to the mother.			K3.1
2.	Screen the mother's bed.			S5.1
3-	Ask the women & family members if the women's face or hands appear swollen.			C1.1
4-	Inspect the women's face, extremities and sacral area for signs of pitting edema			S4.1
5-	Press each area firmly with thumb or index finger for several seconds & release.			S4.1
6-	Evaluate the Extensiveness of edema, Depth of depression & Length of time it takes to clear.			S5.1
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			S5.1
8-	Record your findings & compare your findings with those previously recorded			S5.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
K3.1 (1)	
S4.1 (2)	
S5.1 (4)	
C1.1 (1)	
TOTAL (8)	

NAME & SIGNATURE OF EVALUATOR:……

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NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Assessment of Uterine Contractions (1st stage of labor)

S. NO.	STEPS	Performed		CLO'S
Preparation of patient &equipments		**Yes**	**No**	
1.	Explain procedure to the woman.			K3.1
2.	Ensure woman's bladder is empty.			S5.1
3.	Assemble equipments: • Screen • Wrist watch • Stethoscope / Doppler			K1.1
4.	Put the mother in dorsal recumbent position & screen the mother bed.			S4.1
Procedure				
5.	Assist the woman to relax by encouraging her to breathe naturally & to take deep breaths during contractions.			C1.1
6.	Place fingertips of one hand on uterus, keep fingertips relatively still rather than moving them over uterus.			S4.1
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.			S5.1
8.	Auscultate fetal heart rate after each contraction reading.			S5.1
9.	Monitor the vital signs for the woman.			S5.1

10.	Observe the woman for any abnormal uterine contractions and fetal heart rate.			S5.1
11.	Wash hands and document the finding.			S5.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
K1.1 (1)	
K3.1 (1)	
S4.1 (2)	
S5.1 (6)	
C1.1 (1)	
TOTAL (11)	

NAME & SIGNATURE OF EVALUATOR:……

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NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: External electronic fetal monitoring

S. NO.	STEPS	Performed		CLO'S
Preparation of patient &equipments		**Yes**	**No**	
1.	Explain procedure to the woman.			K3.1
2.	Assemble equipments: • Monitor • Two elastic monitor belts • Tocodynamometer • Ultrasound transducer • Ultrasonic gel			S4.1
Procedure				
3.	Turn on the monitor.			S4.1
4.	Place the two elastic belts around the woman's abdomen.			S5.1
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.			S5.1
6.	Note the uterine contraction tracing. The resting tone tracing should be recording on the 10 or 15 mm Hg pressure line.			S4.1
7.	Apply the ultrasonic gel to the diaphragm of the ultrasound transducer.			S5.1
8.	Place the diaphragm on the maternal abdomen in the midline between the umbilicus and the symphysis pubis.			S4.1
9.	Listen for the FHR.			S5.1
10.	When the FHR is located, attach the second elastic belt snugly to the transducer.			S5.1

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.			K1.1
12.	Document about maternal and fetal condition.			S5.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
K1.1 (1)	
K3.1 (1)	
S4.1 (4)	
S5.1 (6)	
TOTAL (12)	

NAME & SIGNATURE OF EVALUATOR……

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NAME OF STUDENT: …… I.D. NUMBER……..

CLASS: 3RD YEAR / 6TH LEVEL DATE:……..

PERFORMANCE CHECKLIST: Immediate newborn Care

S. NO.	STEPS	Performed		CLO'S
Preparation of patient &equipments		**Yes**	**No**	
1.	Keep the room warm.			S4.1
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.			S4.1
3.	Wash hands and wear gloves.			S4.1
4.	Put the newborn under radiant warmer in Side-lying or Trendelenburg position to prevent aspiration of secretions.			S5.1
Procedure				
5.	Dry the baby thoroughly and remove the wet linen.			S5.1
6.	If needed suction the mouth first and then the nose gently.			S5.1

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.			S5.1
8.	Complete **1** minute &**5** minute Apgar score.			S4.1
9.	Measure vital signs pulse, respiration & temperature.			S4.1
10.	Measure length, weight, head circumference, chest circumference & abdominal circumference.			S4.1
11.	Place Identification tag on the newborn on wrist or ankle (mother name, hospital no, sex, weight of newborn).			S5.1
12.	Give eye care to the newborn.			S5.1
13.	Check the reflexes present in the newborn.			S4.1
14.	Assess for any gross abnormality, congenital defects in head, eyes, ears, chest, spine,. face, nose, abdomen, anus, external genitalia & extremities.			S4.1
15.	Administer Inj. Vitamin K (I. M)			S5.1
16.	Wrap the baby & give to mother.			S5.1
17.	Advice the mother to breast feed.			C1.1
18.	Complete charting, reporting &recording			S5.1
19.	Replace equipment after use & care for it.			S5.1
20.	Wash hands.			S4.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
S4.1 (9)	
S5.1 (10)	
C1.1 (1)	
TOTAL (20)	

NAME & SIGNATURE OF EVALUATOR:……

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NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Assessment of uterine fundus postpartum

S. NO.	STEPS	Performed		CLO'S
Preparation of patient &equipments		**Yes**	**No**	
1.	Explain procedure to the woman & maintain privacy.			K3.1
2.	Ensure woman's bladder is empty.			S4.1
3.	Assemble equipments: Clean & Sterile gloves Screen Sterile pad			S4.1
4.	Assist woman into supine position.			S4.1
5.	Assist the woman to relax by encouraging her to breathe naturally.			C1.1
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.			S5.1
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.			S5.1
8.	Measure the top of the fundus in fingerbreadths above, below or at the fundus.			S4.1
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.			S5.1
10.	If the bladder is distended, use nursing measures to help the woman void.			S5.1
11.	Measure urine output for the next few hours until elimination is established.			S5.1
12.	Assess the lochia.			S4.1
13.	Remove bloody pads, clean perineum & apply sterile perineal pad.			S4.1

14.	Record consistency & location of the fundus, bleeding & perineum.			S4.1
15.	Report a fundus that does not stay firm.			S4.1
16.	Make the woman comfortable and wash hands.			S5.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
K1.1 (1)	
S4.1 (8)	
S5.1 (6)	
C1.1 (1)	
TOTAL (16)	

NAME & SIGNATURE OF EVALUATOR:…….

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NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Breast examination

		Performed		CLO'S
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			S4.1
Procedure				
1.	Prepare equipment			S4.1
2.	Welcome the woman and explain the procedure to her.			C1.1
3.	Put the mother in a sitting position.			S5.1
4-	Palpate the supra clavicle area.			S5.1
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.			S5.1
6-	Instruct woman to lie down with her right arm under her head and place a small pillow under her right shoulder.			S4.1
7-	With the flatten surface of 2 or 3 fingers gently palpate breast tissue beginning at the upper outer quadrant.			S5.1

8-	Repeat procedure for other breast.			S5.1
9-	Check the areola area for crustiness, nipple, and discharge signs of infection.			S4.1
10-	Record finding and report abnormalities to the physician.			S5.1
11-	Instruct the mother to perform breast self-examination and encourage her to ask any questions			C1.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
S4.1 (4)	
S5.1 (6)	
C1.1 (2)	
TOTAL (12)	

NAME & SIGNATURE OF EVALUATOR:……

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NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Breast care

		Performed		CLO'S
Preparation		**Yes**	**No**	
1	**Assess** The breast tissues for lump and cysts that may be require further medical evaluation Breast size ,shape and symmetry, 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			S4.1
2	**Prepare equipment s in suitable bed-side table** Macintosh Water & soap Disposable Gloves Cotton &gauze			S4.1
Procedure				
3	Wash hands with water & soap			S4.1
4	Explain procedure to the mother and maintain privacy			K3.1
5	Put the mother in a sitting position.			S4.1
6	Expose the Mother's Breast and place Macintosh Under breast.			S5.1
7	Inspect and palpate the Breast and nipple.			S5.1
8	Massage the Breast from up to down toward the areola and nipple.			S5.1

9	Express few drops of colostrum or Milk from the Breast.			S5.1
10	Clean the Breast by warm water beginning with nipple and areola and going outward in a circular motion.			S5.1
11	Dry the breast and apply a piece of gauze on the nipple and areola.			S5.1
12	Clean the other breast in the similar manner.			S5.1
13	In case of breast engorgement ask mother to wear suitable bra and express the milk out as much as possible.			C1.1
14	Discard paper bag with wastes.			S4.1
15	Cover the mother's Breast.			S5.1
16	Instruct mother about importance of Breast care and Breast feeding.			C1.1
17	Record observations.			S5.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
K3.1 (1)	
S4.1 (5)	
S5.1 (9)	
C1.1 (2)	
TOTAL (17)	

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NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Perineal examination

S. NO.	STEPS	Performed		CLO'S
Preparation of patient &equipments		**Yes**	**No**	
1.	Explain procedure to the woman & maintain privacy.			K3.1
2.	Ensure woman's bladder is empty.			S4.1
3.	Prepareequipments: Screen. Sterile gloves Macintosh Flash light.			S4.1
4.	Request the mother to assume a Sims position & flex her upper leg & expose perineum.			C1.1
Procedure				
5.	Wash hands and wear gloves.			S4.1
6.	Place macintosh under mother's hips.			S5.1
7.	Lower the perineal pad & lift the superior buttocks.			S5.1
8.	Note the extent & location of edema or bruising.			S4.1
9.	Examine the episiotomy or laceration for (REEDA) Redness, Ecchymosis, Edema, Discharge & Approximation.			S5.1
10.	Note number & size of hemorrhoids.			S4.1
11.	Instruct mother to turn on back & cover her.			S4.1
12.	Remove the equipments& wash hands.			S5.1
13.	Report any abnormalities.			C1.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
K3.1 (1)	
S4.1 (5)	
S5.1 (5)	
C1.1 (2)	
TOTAL (13)	

NAME & SIGNATURE OF EVALUATOR:…….

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CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Perineal care

S. NO.	STEPS	Performed		CLO'S
Preparation of patient &equipments		**Yes**	**No**	
1.	Explain procedure to the woman & maintain privacy.			K3.1
2.	Ensure woman's bladder is empty.			S4.1
3.	Prepareequipments: • Sterile gloves. • Macintosh • Paper bag. • Sterile Perineal Pad. • Dressing set • Sterile cotton swabs in bowl • Antiseptic solution • Bedpan (if required)			S5.1
4.	Position the mother in dorsal recumbent position.			S5.1
Procedure				
5.	Wash hands and wear gloves.			S4.1
6.	Place macintosh under mother's hips.			S4.1
7.	Remove soiled pad from front to back.			S5.1
8.	Observe color, amount and odor.			S5.1
9.	Wrap soiled pad &throw it in paper bag.			S5.1
10.	Test the temperature of the antiseptic solution and pour over vulva.			S5.1

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.			S5.1
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.			S5.1
13.	Rearrange bed, clothes & make the women comfort.			S4.1
14.	Remove screen & equipment from bed side and wash hands.			S4.1
15.	Record and report the date & time of procedure, discharge, genitalia condition and any abnormalities.			S4.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
K3.1 (1)	
S4.1 (6)	
S5.1 (8)	
TOTAL (15)	

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NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL **DATE:……..**

PERFORMANCE CHECKLIST: Role of Scrub Nurse

STEPS	**Performed**		**CLO'S**
	yes	no	
1. Discuss any questions about the nature of the case with surgeon.			C1.1
2. Scrubbing, gowning and gloving.			S4.1
3. Arrange sterile instruments table.			S4.1
4. Check all types of instrument to be used in the operation (function, number).			S4.1
5. Arrange sutures, needles, blades and other necessary sterile equipment			S4.1
6.Aiding the surgeon in gowning & gloving.			S4.1
7. Aiding in draping the patient.			S5.1
8. Observe the team for breaks in aseptic technique.			S4.1
9.Assist surgical team during operation (handling by intelligent, speed, and accurate way.			S4.1
10. Observe steps of operation.			S4.1
11.Keep an accurate count of swabs if used, needles, sponges and instruments during operation .			S5.1
12.Keep instruments dry & clean and remove blood from it.			S5.1
13.Before the surgeon sutures the cavity, check swabs, packs, instruments, needles & sponges count with chart that with circulating nurse.			S5.1
14.Clean the site of incision from the blood with antiseptic solution and appropriate wound dressing & covering.			S5.1
15.Remove the draps, Lenin, all instruments for cleaning.			S5.1
16.Care of instrument after operation			S5.1
17. Rearrangement for OR.			S5.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
C1.1 (1)	
S4.1 (8)	
S5.1 (8)	
TOTAL (17)	

NAME & SIGNATURE OF EVALUATOR:……..

NAME OF STUDENT: …… I.D. NUMBER:……..

CLASS: 3RD YEAR / 6TH LEVEL DATE:……..

PERFORMANCE CHECKLIST: Role of Circulating Nurse

STEPS	Performed		CLO'S
	Yes	NO	
A. Preparation phase include **1.**Discuss any questions about the nature of the case with surgical team and use patient file. ▪			C1.1
2.Prepare operating room through: ▪ Check the room for cleanliness.			S4.1
▪ Check operating room light, bed, suction, diathermy, instrument table & anesthetic machine in good function.			S4.1
▪ Collect all supplies & equipment are required according to type of operation			S4.1
3.Prepare the patient through ; ▪ Check patient NPO for proper time according to type of operation			S4.1
▪ Check bladder preparation via toilet or catheterization.			S4.1
▪ Check bowel preparation according operation.			S4.1
▪ Check removes jewelries and metals.			S4.1
▪ Check preparation to the site of operation according type of operation.			S4.1
▪ Check patient hygiene via partial or total bath.			S4.1
▪ Check identification band of patient			S4.1
▪ Check patient medical file which include assessment papers, laboratory reports, x-rays, examination which include (ECG, Echo and abdominal ultra sound).			S4.1
▪ Check preoperative medication.			S4.1
B. Role at beginning of operation include			S5.1

▪ Receive the patient in the theater on a trolley and never be left alone.			
▪ Reassure the patient by supporting and talking with her to relieve anxiety.			S5.1
▪ Put the patient in proper position according operation.			S5.1
▪ Open sterile draping packet for scrub nurse.			S5.1
▪ Assist scrub nurse and surgeon during gowning.			S5.1
▪ Open sterile supplies, surgical instruments, needles and sutures according operation for scrub nurse at all phases.			S5.1
▪ Check number of instruments, sponges and needles with scrub nurse.			S5.1
▪ Monitor draping procedure.			S5.1
▪ Connect diathermy cable and suction tube and fixed them for scrub nurse			S5.1
▪ Maintain sterile field at all phases			S5.1
C. Role during operation include ▪ Monitor steps of operation.			
▪ Keep environments quiet, avoid noise and keep doors closed			C1.1
▪ Provide container for specimens collected during operation and labeled them.			S5.1
D. Role at the end of operation ▪ Before closed the incision recheck the number of instruments, sponges and needles with scrub nurse and surgeon.			S5.1
▪ Complete any records.			S5.1
▪ Evaluate patient care.			S5.1
▪ Transport the patient to recovery room.			S5.1
▪ Help scrub nurse to send solid instruments for sterilization.			S5.1
▪ Recheck of all supplies and equipment inside the operating room.			S5.1
▪ Rearrangement of OR.			S5.1

RESULT:

CLO	***STUDENT'S PERFORMANCE***
C1.1 (2)	
S4.1 (12)	
S5.1 (18)	
TOTAL (32)	

NAME & SIGNATURE OF EVALUATOR:…….