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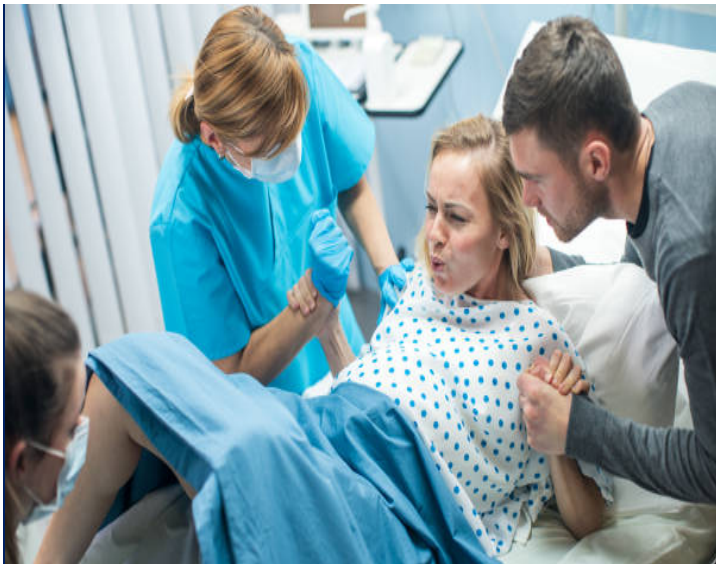

Labour Room Manual

Manual ID No:

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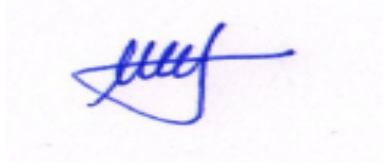
Annual Documents adequacy & Change Requirements Review

Sr.No	SOP /Doc No	Documents Name	Issue. No	Rev.No	Review Date	Change	Rev No	Revision Date	Reason for Change	Amendment
1	SDH/LR /01	LABOUR MANUAL	1	1	20-Nov-22	No Any change review completed	1	20-Nov-23	No Any change review completed	No Any Amendment History
		Original Date	**Effective Date**		**Next date of revision**		**Issue NO**			
		01 Oct 19	**20 November 2023**		**20 November 2024**		1			

Reviewed & Prepared By		**Recommended By**	**Approved By**
Dr.Vaishali Kiran	Mrs.Shraddha suryavanshi	Dr.H.Kalgaonkar	Dr.S.S.Deepak
Gaynaecologist	Quality Co-ordinator	Chief Medical Administartor	Chairman & Managing Director



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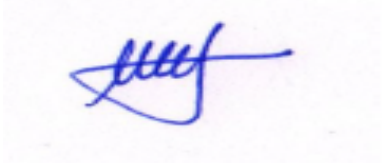
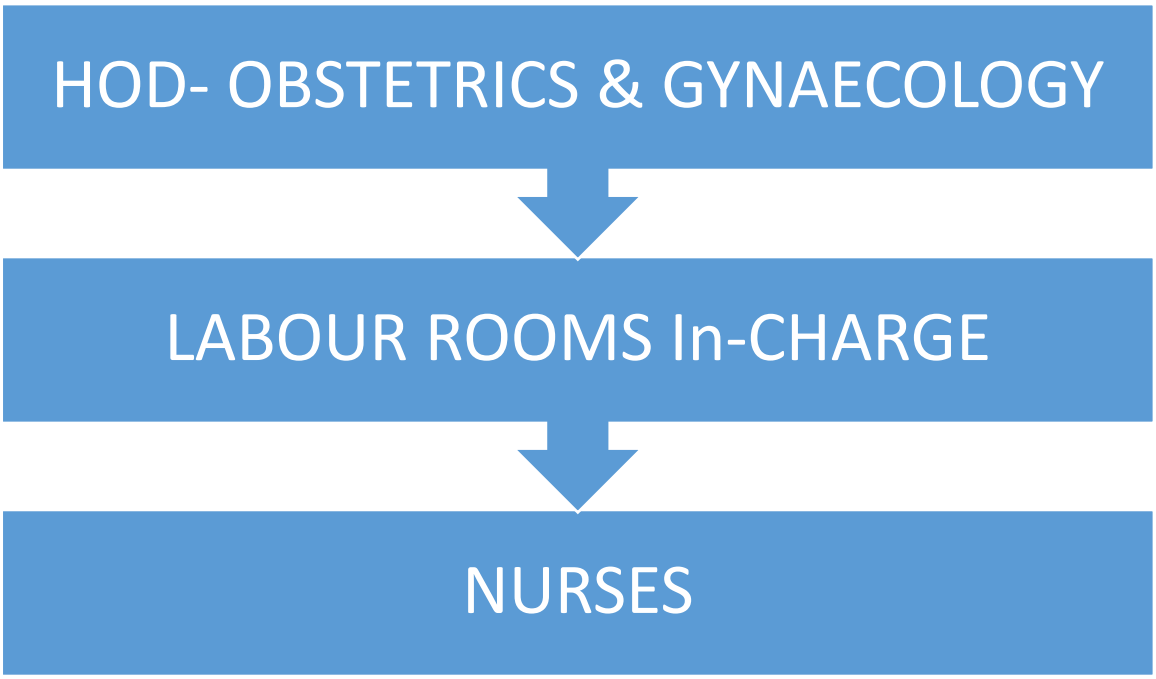



SAIDEEP HEALTHCARE & RESEARCH PVT. LTD.	**SAIDEEP HOSPITAL** **LABOUR ROOM MANUAL**	Doc No	SDH/LR/01
		Issue No	01
		Rev No.	00
		Date	1 Oct 2019
		Pages	1
	Contents		

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

Organisational Chart



STAFF IN CHARGE:

1. **Management of Patient Care:**
    - Receiving the patient.
    - Assessment of nursing needs and plans.
    - Transferring the patients according to the department,
    - Maintenance of a safe environment for the patient and personnel.
    - Management of emergencies.
    - Assign duties.
    - Delegate responsibility.
    - To follow all standard infection control practices in the department(Refer infection control practice manual)
    - Supervise nursing and non nursing functions of the personnel.
    - Supervise the safety and comfort of the patients.
    - Maintenance of supplies and equipments.
    - Information processing
    - Check the cleanliness of the unit.
    - Supervise housekeeping, attenders and security functioning.
    - To take consent and to ensure that for high risk consents are taken by the doctor
    - Write the evaluation reports about the personnel working with him/her and send it to the concerned authorities.

2. **Teaching Functions:**
    - Organize orientation programmes for new staff.
    - Organize formal and informal ward teaching

- Give incidental teaching and education to patients, relatives, nursing students and staffs.
- Conduct in-service education for the personnel working with him/her.

3. **Self Development.**
   - Doing self learning for leadership and team work for setting high standards of patient care.
   - Utilizes all learning opportunities that are found around him/her.
   - Attend educational meeting at least once in a year.

STAFF NURSE:

- Receive the patient immediately.
- To take consent and to ensure that for high risk consents are taken by the doctor.
- Check the vital signs and inform the concerned doctor.
- Carry out doctor's orders as prescribed.
- Render direct nursing care to sick patients.
- To follow all standard infection control practices in the department(Refer infection control manual)
- Educate the patients/bystanders according to the need.
- Maintain treatment report.
- Hand over the patients to the ward staff during transfer.
- Administer all the drugs according to orders of the doctors.
- Ensure sending of laboratory specimens for investigations.
- Take proper care of patient's personal belongings.
- Render pre and post operative care.
- Take rounds with doctors and report patient's condition.

NURSING ASSISTANTS:

- To assist the nursing staff to carry out the nursing care.
- Help in checking vital signs if asked for.
- Help the nursing staff in carrying out difficult procedures.
- Help the staff nurse and attenders for transferring the patient.
- To follow all standard infection control practices in the department(Refer infection control manual)
- Maintain inventory of item in relation to their work area.
- To help nursing staff and attender to send samples for investigations and to collect report.
- To maintain total cleanliness of unit.
- To do any other responsibility assigned by supervisors from time to time

ATTENDERS:

- ✓ To transfer the patient to and from ICU upon getting orders.
- ✓ To give specimens for investigation and collect lab report.
- ✓ To follow all standard infection control practices in the department(Refer infection control manual)
- ✓ To collect all procedure reports.
- ✓ To maintain inventory of items in relation to their work area.
- ✓ To do any other responsibility assigned by the supervisor from time to time.
- ✓ To maintain total cleanliness of unit.

SWEEPERS:

- To maintain the cleanliness of the unit.
- To clean the floor as soon as a patient is shifted out of the department.
- To follow all standard infection control practices in the department.
- To help the Attenders to shift the patient from the departments.

- To follow the waste disposal protocols strictly.

SECURITY STAFF:

- Shall inform the staff regarding the entry of the patient.
- They shall be overall responsible for security aspects.
- Shall keep the valuables of the unknown patients, in their custody and hand over them to the Security Supervisors/General Manager who further hand over these to relatives after obtaining a receipt.
- Assist in local shifting of the patient as per the need and urgency.

PURPOSE:

- To establish interpersonal relationship with the patient.
- To establish a sense of caring for the patient as an individual.
- To be responsible for delivering high quality supportive care.

MAINTAINING PROPER BODY ALIGNMENT

- Determine need to assist the patient to various positions.
- Determine presence of IV equipment, surgical wounds, drains, or attached mechanical equipment.
- Take care of urinary catheters / IV Cannula lines
- Determine need for extra pillows, level and position of bed.
- Take care of the pain that patient experience on shifting.
- Don gloves and gown is necessary.
- Assist patient to desired position for proper body alignment (use assistance of another health-care provider if patient is unable to self assist).
- Use the draw sheet or pull sheet.
- Adjustable trolley is used to transfer the patient.

CORRECT LIFTING TECHNIQUES

- To provide the patient and health-care provider with knowledge to perform correct lifting techniques, thus preventing pain stress, fatigue, trauma, and injury to promote comfort.
- Determine need to assist in the process of lifting.
- Assess the knowledge the patient has about the process of lifting.
- Take care to minimize the pain during lifting the patient.
- Risk for injury related to improper lifting techniques should be born in mind.
- Position will be comfortable and enhance proper body alignment at all times while performing the lifting process.
- Patient must experience minimal discomfort in attaining proper body posture for lifting.

- Use of rollers specifically designed for shifting from trolley/bed encouraged.
- Use gloves and protective clothing where ever necessary.

SHIFTING THE PATIENT TO OTHER UNITS

- Assess the reason for shifting
- Inform the nurse In-charge about the transfer
- Check the belongings of patient and keep ready for shifting
- Complete patients chart and make it up to date.
- Assess patients physical condition and determine the mode of transportation
- Assist in transferring patient to stretcher / wheel chair using proper body mechanism
- Perform final assessment of patients activity
- Accompany the patient to the receiving unit
- Hand over all documents and belongings to the receiving nurse and ensure that the item given are recorded.
- Complete all the documentation.

HANDOVER THE PATIENT DURING SHIFTS

- Handover process is done at the end of each shift by the assigned nurse to the next duty assignee in the presence of ward in-charge or shift in-charge with the following details.
- Patients chart to update with vitals/intake output chart details/ details about the assessment and reassessment + nutritional assessment + patient elimination
- Assess patients physical condition by going to the bed side along with the patient file
- Medications given till the time and medications to give in the next shift will be explained in the handover.
- Details of I.V infusions / Blood transfusions with proper documentation.
- Cross consultations
- Details about the delivery process
- Special instructions, lab reports, pending investigations, verbal orders, NPO orders if any

- Any drug allergies reported

- Admit women with contractions, leaking or bleeding per vagina, reduced or absent fetal movements and women less than 22 wks of generation, if they have pregnancy induced hypertension (PIH) or heart disease.
- If patients are referred from other hospital the reference letter should be kept on patient's folder for physician's reference.
- Contra indications to giving enema are
  - Severe Pregnancy Induced HTN (PIH)
  - Cardiac disease
  - Pre term labor
  - Leaking P/V
  - Bleeding P/V
  - De creased fetal movements
  - Women in 2nd stage of labor
  - Grand multi Para gravida
  - Mal presentations
- Welcome patient to unit
- Collect history
- Explain admission procedure to patient and relatives
- Check height & weight of patient
- Collect sample of blood and urine.
- Help patient to change clothes to hospital gown and handover valuables to the relatives.

- Check vital signs
- Assess maternal and fetal condition
  - Collect relevant information from patient

    E.g.: Any bleeding P/V

    Fetal movements

    Gestational age
  - Perform a careful abdominal examination which includes inspection, palpation, and auscultation of fetal heart sounds and monitoring of contraction.
  - Check for conditions of membranes
  - Prepare pubic area.
  - Administer an enema unless contraindicated.
  - Document time of admission, reason for admission findings and procedure done.

Instruct patient to lie in bed allotted to her in labor room and inform physician about admission.

A. Performing an Antenatal abdominal examination and palpation procedure

- Explain to the woman what will be done and how she may cooperate.
- Instruct woman to empty the bladder.
- Draw curtains around the bed for providing privacy.

Inspection

- Position the woman for examination
- Inspect the abdomen for scars, Hernia, Linea Niagra, Striae Gravidarum, Contour of the abdomen, state of umbilicus.
- Determine the fundal height using the ulnar side of the palm.
- Measure the fundal height using
  - measuring tape
  - Measure the abdominal girth by encircling the women's abdomen with a tape machine at the level of the umbilicus.

Abdominal Palpation or leopold's maneuvers

- Instruct the women to relax her abdominal muscles by bending her knee slightly and doing relaxation breathing.
- Be sure your hands are warm for beginning to palpate, rest your hand on the mother's abdomen lightly while giving explanation about the procedure.
- For the technique of palpation

  Use the flat palmer surface of fingers and not finger tips. Keep fingers of hands together and apply smooth deep pressure as firm as is necessary to obtain accurate findings.

- Perform the first palpation

1. Face the woman's head

2. Place your hands on the sides of the fundus and curve the fingers around the top of the Uterus.

3. Palpate for size, shape consistency and mobility of the fetal part in the fundus.

Do the lateral palpation

- Continue to face the woman's head
- Place your hands on the both sides of the uterus about midway between the symphysis pubis and the fundus.
- Apply pressure with one hand against the side of the uterus pushing the fetus to the other side and stabilizing it there.
- Palpate the other side of the abdomen with the examining finger from the midline to the lateral side and from the fundus using smooth pressure and rotator movements.
- Repeat the procedure for examination of opposite side of the abdomen.

- Pawlik's grip
  - Continue to face the woman's head, make sure that the woman has her knees bent.
  - Grasp the portion of the lower abdominal immediately above the symphysis pubis between the thumb and middle finger of one of your hand.
- Pelvic Palpation
  - Turn and face to the woman's feet

- Place your hands on the sides of the uterus, with the palm of your hands just below the level of the umbilicus and your fingers directed towards the symphysis pubis.
- Press deeply with your finger tips in to the lower abdomen and move them towards the pelvic inlet.
- The hands converge around the presenting part when head is not engaged.
- The hands will diverge away from the presenting part and there will be no give or mobility if the presenting part is engaged or dipping.

Auscultation

- Place fetoscope or stethoscope over the convex portion of fetus, closest to the anterior uterine wall.
- Inform the mother of your findings. Make her comfortable
- Replace articles and wash hands.
- Record in the patient's charts the time, findings and remarks if any.

B. Preparing a Prenatal Patient for Ultrasound Examination

A. Trans-abdominal ultrasound scan

- Explain to the woman, the nature of examination, purpose and her role.
- Instruct the women to drink eight glasses of water in 2 hours prior to the examination if in the first trimester of pregnancy. (in second and third trimesters, drinking water is not necessary)

  Instruct the woman not to void until examination is over
- The patient is assisted to lie in supine position on the examining table and expose her abdomen from costal margin to symphysis pubis.

- Apply the ultrasound gel generously to the abdomen(A towel or disposable tissues should be provided to the patient to protect her clothing)
- After completion of procedure remove gel from the women's abdomen and assist her to dress back into her clothes.

B. **Trans vaginal ultrasound examination**

- No pre-examination preparation is required
- Explain procedure to the patient.
- Instruct patient to remove any clothing below waist.
- Place the woman in lithotomy position and place a pillow under her buttocks to raise the pelvic area.
- Place a transducer sheath or a condom, filled with ultrasound gel over the vaginal transducer.
- The transducer is then inserted through the introitus into the mid vagina by Gynecologist/ Sonologist.
- Remove the condom after the examination and clean the transducer with disinfectant.
- Assist the woman to clean herself and change to her clothes.
- Forward the findings of the ultrasound unit or physician who has requested the test.
- Wash hands and record the procedure and findings.

Definition of Delivery Process

Labor process is a serious of event that takes place in genital organs in an effort to expect the variable products of conception out of womb (uterus) through the vagina into the outer world.

Aim & Objectives of educating about delivery process

- To relieve anxiety
- To take proper care during delivery process
- To provide calm & quit environment
- To prevent maternal & Fetal complications
- Take proper care leads to healthy mother and baby.

Care and Management

Cleanliness and comfort

Explain to antenatal term mother to take cleanliness and comfort that are following

Bowel and bladder preparation

At the last stage of pregnancy, the descending uterus engages head compress the bowel and bladder, this time women feels loaded rectum and bladder and then feels repeated voiding. In this time mother to take self care due to cleanliness and comfort.

Before labor process, the nurse should be explained the bowel preparation to mother with enema.

Skin Preparation

The nurses should explain the mother regarding skin preparation procedures. Explain with importance to prevent infection of mother and baby.

Bath

Discuss the importance of warm bath, for women in normal labor, a warm bath can be an effective form of pain relief that allows increased mobility with no increase incidence of adverse outcome for mother or baby.

Clothing

Advice women to wear loose dresses it may feel more convenient immediately to change wet and blood stained clothes.

Communication

The nurse communicates with all methods to relieve the fear and anxiety.

- Explain the labor process
- Explain each procedure to mother before doing
- Discuss pain including management

Vaginal Examination

Vaginal examination is the main part of identification process of labor. Explain the mother the procedure and before examination to conform the bladder voided. Explain the importance of examination that and identify the presentation & position. Assess process and delay in labor etc.

Labor Process

- Explain labor process and stages of labor process. Teach the physiology of 1st, 2nd & 3rd stage of labor.
- The duration of 1st stage labor process in primi mother is 12 hours, in multi 6 hours, 2nd stage in primi 2 hours and multi mothers in 30 minutes. 3rd stage primi is within 15 minutes, in multi 5 minutes.

- 1st stage duration from uterine contraction to full dilation of cervix is 10cm. 2nd stage is full dilation cervix to delivery of baby. 3rd stage is delivery of placenta.
- 1st stage in uterine action and mechanical factors.
- In second stage mechanism of labor with or without episiotomy.
- Explain the episiotomy and suturing.
- In 3rd stage separation and descent of the placenta.

Medicines

Explain to each medication before administration

Nutritional and fluid management

In the time of labor, the vigorous muscles contraction of the uterus demands a continuous supply of glucose. Explain the mother to importance of IV infusion and take foods and soft diet. Advise to take more fluids and soft diet.

Post natal care.

Explain postnatal care to the mother

- - Exercises
- Lifting and carrying
- Pelvic floor exercise
- Abdominal exercise
- Transverse exercise
- Nutrition

  Advice to mother to take special nutritional food, fluid and easily digestible food
- Personal hygiene
- Baby care and breast feed: - Advise the mother to provide breast feed to the baby at least a period of 6 months.

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	Patient Handling & Education about Delivery Process		

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

Procedure

- Check medication order and identify the patient.
- Explain procedure, and instruct her to empty bowel and bladder.
- Provide privacy.
- Position the patient in dorsal recumbent, sin's and drape.
- Prepare medication.
- Put on clean gloves.
- Inspect perineum/vagina for any odour, discharge etc.
- Provide perineal care or encourage patient to perform her own perineal care in toilet.
- Administer vaginal medication

  1. Lubricate gloved index finger
  2. Lubricate the rounded smooth end of the medication.
  3. Insert medication about 8-10cm.
  4. Ask patient to remain lying in supine position for 5-10 minutes. The hip may be elevated on a pillow.
- If using as application,

1. Gently insert the application about 5cm and slowly push the plunger until applicator is empty.

2. Discard applicator if disposable or clean it according to the order.

3. Ask the patient be in supine position for 5-10min following insertion.

- Dry perineum using towel
- Apply a clean perineal pad if there is excessive drainage
- Remove gloves and wash hands
- Dispose off all used articles and replace all reusable articles
- Document all relevant information.

tted to her in labor room and inform physician about admission.

PROCEDURE:

Oxytocin induction:

- Explain to patient what will be done, the purpose of it and how she may co-operate.
- Wash hands
- Check the chart for doctor's order.
- Instruct her to empty bowel and bladder
- Provide privacy
- Prepare the perineal area as for labor
- Check the fetal heart rate, uterine contraction rate, abdominal and vaginal findings
- Maintain labor progress chart every 15 minutes, and monitor BP every two hours.
- Set up the I.V tubings, I.V pumps and adjust the drop/min.
- Add **5 units in 500ml** oxytocin in the I.V bottle after adjusting the drops/min.
- Gradually increase the drops after ensuring that **all the parameters are normal.**

  Indications for stopping:

  - Strong contractions lasting over 60 seconds and occurring frequently with intervals less than 3min.
  - Tonic uterine contractions
  - Fetal distress
  - Deterioration in the woman's condition
  - Occurrence of increased or decreased fetal movement.

COMPLICATIONS:

- Urine rupture
- Water retention(intoxication)
- Hyponatremia

Prostaglandin induction:

- Wash hands.

- Check the chart for doctor's order.
- Instruct mother to empty bowel and bladder
- Provide privacy
- Prepare the perineal area as for labor.
- Perform vaginal examination.
- Insert 25 or 200 mcg prostaglandin E2 or E 1 gel in to posterior fornix close to cervix.
- Instruct the woman to stay recumbent as contractions begin.
- Monitor cervical changes using **Bishop's score.**
- **Bishop's score**

Score/components	0	1	2	3
Dilation of cervix	0	1-2	3-4	>5
Effacement of cervix	0-30	40-50	60-70	>80
Consistency of cervix	Firm	Medium	Soft	-
Position of cervix	Posterior	Midposition	Anterior	-
Stations of presenting part	-3	-2	-1	+1, +2

- Monitor uterine contractions and fetal heart rate continuously.
- Repeat the dose of E2 or E1 if required after 6 to 8 hours according to **Gynecologist's** order.

Adverse reaction

- Diarrhea
- Nausea and vomiting
- Stomach cramps

- Fever and chills
- Flushing
- Headache
- Hyperstimulation
- Foetal passage of meconium
- >12 uterine contraction in 20 min

Surgical induction:

AROM (Artificial Rupture of Membrane)

- Wash hands using surgical asepsis.
- Help the mother to lie down in Lithotomy position
- Follow strict aseptic technique.
- Wear sterile gloves, gown, and mask.
- Clean the perineum using aseptic technique
- **Gynecologist** introduces two fingers of left hand inside the vagina, up to the cervical canal and beyond the internal os.
- **Gynecologist** assesses the membranes, and places palmar surface of the left hand upwards.
- **Gynecologist** introduces a long Kocher's forceps with blades closed up to the membranes along the palmar aspect and ruptures the membranes.
- Assess fetal heart rate, note the color, amount of the amniotic fluid, status of cervix, station of head, presence or absence of cord prolapsed.
- Administer prophylactic antibiotics as per order.
- Record the date and time and the type of induction done.

PROCEDURE:

- Explain procedure to the antenatal mother
- Ask mother to void if the bladder is not empty.
- Explain how she should relax during the examination
- Read the chart for previous findings
- Position the mother in a dorsal recumbent position with knees flexed.
- Drape the patient
- Do a surgical hand washing
- Don sterile gloves
- Observe the external genitalia for the following;
    - ✓ Signs of varicosities, edema, vulval warts or sores
    - ✓ Scar from previous episiotomy or laceration
    - ✓ Discharge or bleeding from vaginal orifice
    - ✓ Color and odour of amniotic fluid, if membranes have ruptured.
- Cleanse the vulva and perineal area.
- Dip the first two fingers of the right hand in to the antiseptic cream.
- Holding the labia apart with thumb and index fingers of the left hand, insert the lubricated fingers in to the vagina, palm side down, pressing downwards.
- With the fingers inside, explore the vagina for required information taking care not touch the clitoris or anus. Note the following:

1.0 The feel on touch of vaginal walls

1.1 Consistency of vaginal walls

1.2 Scar from previous perineal wound, cystocoele or rectocoele.

- Examine the cervix with the fingers in the vagina turned upwards. Locate the cervical os by sweeping the fingers from side to side. Assess the cervix for:

1. Effacement
2. Dilatation

3. Consistency
4. Fore waters

- Assess the level of presenting part in relation to maternal ischial spines.
- Identify the presentation by feeling the hard bones of the skull, the fontanalle and sutures.
- Identify the position by feeling the features of the presenting part.
- With the fingers, follow the sagital suture to feel the fontanalle
- Assess the moulding, by feeling the amount of overlapping of skull bones.
- At the completion of the examination, withdraw fingers from vagina; take care to note the presence of any blood or amniotic fluid on the examination fingers.
- Remove gloves and wash hands
- Auscultate the fetal heart **sound.**
- Assist the woman to a comfortable position and inform her progress of labor.
- Record the findings and observations in the patient's chart and inform the **Gynecologist's** observations and progress of labor.

LABOR: Labor is described as the process by which the foetus, placenta and Membranes are expelled through the birth canal.

NORMAL LABOR:

- This has been described as one in which
- The foetus is born at term and presents by the vertex.
- The process is completed spontaneously.
- The time does not exceed more than 24 hours.
- No complications arise.

THE FIRST STAGE OF LABOR:

The first stage is that from the onset of true labor to complete dilation of cervix.

Equipments Needed To Manage First Stage of Labor

- Patient gown.
- Doppler with jelly.
- NST machine with belts.
- Under pad.
- Proctolysis enema.
- Preparation tray.
  - Razor set with blade.
  - Gloves.
  - Savlon solution.
  - Kidney tray.
  - Cotton.

Vaginal examination tray contains,

- Gloves.
- KY jelly.
- Cotton.

- Betadine solution.
- Curved cocker or spinal needle for ARM.
- Kidney tray
- Sterile pad.
- BP apparatus and stethoscope.
- Thermometer.
- I.V stand.
- Injection tray.
- Required medicine.
- IV set.
- IV fluids.
- Cannula.
- Tegaderm.
- Spirit swab.
- Kidney tray.
- All size syringes.
- Loaded injection hep lock.
- Syringe pump.
- Suction apparatus.

PROCEDURE

ACTION	RATIONALE
Receive the mother to the delivery ward. Explain the Hospital routine. Orientation to the ward to be given.	To relive the fear and anxiety about hospitalization.
Change the hospital dress and remove all the ornaments and hand over it to the relatives and take signature on	For self protection of the patient and hospital staff. Keep the patient ready

the concerned consent. Put the ID band. Give test dose for 2% xylocaine.	for any procedure & identify the patient.
Advise the patient to empty the bladder.	Full bladder interfere with engagement of head and reduce the capacity of uterus to contract and increases the changes of PPH.
Provide a comfortable position.	To make sure the patient is comfortable.
Take the history of the mother about labor. Do abdominal examination, check the FHR, Uterine contraction, Vital signs and any vaginal discharge.	It helps in assessment of the mother and to know the progress of labor.
Give enema as per doctor's order.	Empty the rectum before delivery.
Provide left lateral position.	It prevents the gravid uterus compress the IVC and increases the cardiac out put. It prevents foetal hypoxia.
Inform the doctor on duty.	To do the internal examination and to asses the labor.
Do the NST (Non Stress Test) as per the doctor's order.	To assess the fetal condition.
Start and secure IV line.	To meet any emergency and to give any intravenous injection.
Monitor the uterine contractions. The frequency, length and the strength of the contractions should be noted.	To avoid hyper stimulation of the uterus.

Make sure the bladder is emptied often during 1st stage of labor.	A full bladder prevents engagement of head and delay the progress of labor.
Encourage the mother to take liquid diet or start IV fluid as per order.	To maintain the hydration and the nutritional need of the mother and it helps the mother to with stand the 2nd stage of labor.
PV examination is done every 4th hourly or as required. The effacement, dilation, station of the head, is assessed in PV examination. ARM is done if necessary.	To assess the progress of labor. ARM helps in the progress of labor and colour of the liquor helps to assess the foetal condition.
The foetal heart beat should be carefully counted at the beginning of labor and throughout labor. The normal rate is ranges from 120 to 160 per min.	To know the average rate for this particular fetus is known(base line heart rate)
Make sure that all the equipments are kept ready including the delivery sets.	It prevents delay in managing any emergency situation.
TPR, BP should be checked every 4th hourly.	To know the maternal distress.
Psychological support should be given to the mother and to the family members.	To obtain co operation
Record all the observation noted in the mother and in the foetal heart in the chart.	If the facts are record at once the progress of labor can be assessed by any member of the staff in the absence of the person who made the examination.

Don't allow the mother to strain before the complete dilation of cervix.	To prevent the caput formation and to prevent the oedema of the cervix.
Arrange the sterile trolley with required articles for conducting delivery	To conduct the delivery without delay.
Pre warm the cradle and the baby receiving tray.	To receive the baby in a warm environment.
Arrange the light.	To visualize the area properly.
SECOND STAGE OF LABOR PROBABLE SIGNS OF SECOND STAGE	
No cervix felt on vaginal examination.	
Expulsive uterine contraction.	
Trickling of blood.	This may come from slight laceration of the cervix.
Rupture of membranes.	
Anus pouting and gaping.	When the head has reached the pelvic floor the anus pouts and then gaps.
Tenseness between coccyx and anus.	
Vulva gaping.	This is a more valuable sign in the Primigravida.
Presenting part appearing.	This is usually accepted as being an almost positive sign.

Bulging of perineum.	This is one of the good later signs and usually means that delivery is imminent.
Equipments needed to manage 2nd stage • Sterile tray contains, • Sterile gowns. • Sterile drapers. • Leggings. • Sterile mops. • Sponge holder-2. • Towel clips-4. • Small bowl with cotton. • Episiotomy scissors-1. • Cord cutting scissors-1. • Straight Spencer's wells forceps-3. • Inj xylocaine2% loaded in a 10cc syringe. • Tray to receive the placenta • Suture vicryl 2.0. • Vaccutainers to collect the cord blood. • Gloves of different sizes. • Cap and mask. • Suction catheter. • Perineal pad. • Straight scissors-1. • Mucus extractors.	

Required injections. • Inj. Oxytocin • Inj. Methergin. • Inj. Prostadine. • Inj. Tramadol • Inj. Phenergan. • Inj. Kenadion. • Inj.Pethadine • Inj.Morphine • Inj.Epidosin • Required IV fluids.	
EXTRA ARTICLES • Betadin solution • Inj. 2% Xylocaine. • Sterile gloves. • Additional suture materials. • Catheterization pack. • Identification band for baby.	
PROCEDURE	
ACTION	**RATIONALE**
Provide Lithotomy Position.	To make delivery easier and it helps the mother to bear down comfortably.

On the spot light	To visualize the area.
The doctor gets ready by wearing the cap, mask, sterile gown and gloves.	To conduct the delivery in sterile condition.
Drape the perineal area with sterile towels covering the leg including the buttocks.	
Encourage the mother to bear down. The mother takes deep breath while the uterus is contracting, closes her lips and bears down.	It helps in decent of the head.
Monitor the FHR (Fetal Heart Rate) closely after each contraction.	To assess the fetal condition.
Hydrate the mother during second stage of labor.	To maintain hydration and avoid tiredness.
EPISIOTOMY is given at the time of crowning. The incision is begun in the centre of the fourchette and directed postro–laterally.10ml of 2% xylocaine is used to infiltrate the perineum before doing an episiotomy.	The making of an incision into the perineum to enlarge orifice is known as episiotomy.
Encourage the mother to bear down with each contraction.	It helps in decend of the head.
During the delivery of the head and the shoulder a good perineal support should be given.	To prevent perineal tear.
Once the delivery of the head is over do the suctioning	This to make the air way patent and to

of the oral cavity and nasal suction to be done.	prevent aspiration.
Clamp the umbilical cord, separate the baby from the mother and hand over the baby to Paediatric doctors in pre warmed area. Note the time of delivery and sex of the baby and the identification band to be applied immediately. Inform the customer care for the baby's admission to the hospital.	For the immediate care of baby after delivery.
Administer Inj. oxytocin through the IV drip after delivery of baby according to doctor order.	It helps to shortens the 3rd stage and prevent PPH(Post Partum Hemorrhage)
THE THIRD STAGE OF THE LABOR. The third stage is that the separation and expulsion of the placenta, which lasts from the birth of the baby until the placenta is expelled.	
Observe the sings of placental separation. • Fresh bleeding • Lengthening of the cord • The fundus rises to the umbilicus	It is make sure that the placenta is separated.
Collect the cord blood.	To find out the baby's blood group and Rh factor.
Give controlled cord traction and pull the placenta.	For the complete expulsion of placenta and to prevent uterine inversion.
Receive the placenta in a tray and check the	The incomplete placenta will not allow

membranes and cotyledons are complete and check for any abnormality.	the uterus to contract which will lead to PPH(Post Partum Hemorrhage).
Inj. Methergin is given according to doctors order	It helps in the contraction of the uterus and it prevents the PPH(Post Partum Hemorrhage).
THE FOURTH STAGE OF LABOR The first hour after expulsion of the placenta is sometimes designated the fourth stage of labor.	
Episiotomy suturing is to be done immediately after the expulsion of the placenta.	It prevents the blood loss from the episiotomy site and the healing will be faster.
Remove the clots from the uterus.	It helps in contraction of the uterus
Mop the episiotomy site and check for any extension of episiotomy	To assess the perineal care
Check the vial signs BP, Pulse	
Once the suturing is over clean the area by antiseptic lotion and place the sterile pad over the suture site	This is to prevent infection and to assess the bleeding.
Change the mother's dress and the bed sheets. Put her back to comfortable position. Give some hot drinks.	
Initiate breast feeding within half an hour of birth	To promote rooming and bonding
Replace the articles. Wash the instruments and sent to	

CSSD	
Segregate all the waste and put in proper container. Do not mix any waste.	For proper waste disposal
Keep the unit neat and tidy	
Observe the mother care fully for bleeding and any variation in her vital signs.	To avoid any complications
Make sure the mother pass urine with in half an hour to one hour of delivery	To prevent PPH(Post Partum Hemorrhage)
Give hot water bath and shift the mother to her respective ward with the baby.	
Record all the procedure done on the mother and the baby during labor in the mother chart.	
Replace and re arrange labor room with all the articles to receive next patient.	

PROCEDURE:

- Wear gloves
- Using gloved hands hold the placenta by the cord allowing the membranes to hang
- Identify the hole through which the baby was delivered.
- Insert the hand through the hole and spread out the fingers to view the membranes and blood vessels.
- Remove the hand from inside the membranes and lay the placenta on the flat surface with the fetal surface up. Identify the site of cord insertion.
- Examine the two membranes, amnion and chorion for completeness and presence of abnormal vessels
- Invert the placenta, expose the maternal surface and remove any clots present.
- Examine the maternal surface by spreading it in the palms of your two hands and placing the cotyledons in close approximation(any broken fragments must be replaced before accurate assessment is made)
- Assess for presence of abnormalities such as infarctions, calcifications or succinturiate lobes.
- Inspect the cut end of umbilical cord for presence of three umbilical vessels.
- Measure the length of the umbilical cord by holding it extended against a graduated surface/side of the weighing scale (the length of the cord on the baby may be added to get the total length where applicable).
- Weigh the placenta by placing it on the weighing scale meant for the purpose.
- Place the placenta in the bin for propel disposal.
- Clean the area used for examination of the placenta and the membranes the weighing scale and the bowl.
- Remove gloves and wash hands.
- Record in the patient's chart, the findings of placental examination and weight of placenta, length of the cord and any special observations made.

	SAIDEEP HOSPITAL LABOUR ROOM MANUAL	Doc No	SDH/LR/4.9
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	Performing Placental Examination		

Recommended By	Signature	Approved By	Signature
Dr. Hrishikesh Kalgaonkar Chief Medical Administrator		Dr. S.S. Deepak Chairman & Managing Director	

Definition

Episiotomy is an incision made into the perineum to enlarge the vaginal outlet and facilitate delivery

Articles

Sterile tray:

- Artery forceps
- Thumb forceps
- Bowl
- Episiotomy scissors
- Gauze
- Cotton
- Hole towel
- Gauze pads
- Needle holder

Clean tray:

- Betadine solution
- PPE
- Suturing material
- 1% xylocain
- Syringes

PROCEDURE

- Place the patient on the delivery table in dorsal recumbent position when the fetal head is distending the perineum.
- Infiltrate the perineum using 10ml of local anaesthetic. Wait for 3-5 minutes for the anesthetic to act.

- Place your index and middle fingers in the vagina with palmar side down and facing you. Separate them slightly and exert outward pressure on the perineal body.
- Place the bladed of the scissors in a straight up and down position, so that one blade is against the posterior vaginal wall and the other blade is against the skin of the perineal body with the point where the blades cross at the middle of the posterior forchette.
- Adjust the length of blades of the scissors on the perineal body and predict the length of the incision accordingly.
- A mediosternal episiotomy is cut at a slant, starting at the midline of the fourschette with the points of the scissors directed toward the ischial tuberosity on the same side as the incision.
- A midline episiotomy is cut in the middle of the central tend nous points of the perineum from the posterior fourchette down to the external anal sphincter.
- If a midline episiotomy was cut, palpate for the external anal sphincter.
- Cut again if needed, avoid snipping, two cuts should accomplish the incision.
- Extend the vaginal side of the incision if needed by incising the vaginal band. For this the scissors must come from above the back side of the hand to slide down the fingers and make the cut.
- Apply pressure with 4x4”sponges.
- After completion of delivery assist for suturing of episiotomy incision.
- Wipe the wound area with sterile antiseptic cotton swabs.
- Focus light on the perineal area. Diagnose the degree of perineal teat if any.
- Pack the vagina with vaginal plug or tampon.
- Visualize the apex of the mucosa, starts suturing little above the apex. Appose the vaginal tear by continuous suture using a round body needle.
- Repair the perineal muscles by interrupted sutures; include the deeper tissue to enclose dead space.
- Perineal skin is opposed by mattress suture.
- Remove the vaginal pack which was inserted during suturing.
- Clean the perineal and apply perineal pads.

- Straighten patient's legs and assist her to supine position either legs crosses.
- Wash and drive the instruments used for episiotomy along with those used for conduct of delivery and suturing.
- Record in the labor record, the time of episiotomy was performed, type of episiotomy, suturing carried out and patient's reaction.

PROCEDURE:

- Explain to mother and family the need for forceps delivery.
- Obtain informed consent.
- Assess fetal heart rate.
- Assess the state of cervix, membranes presentation and position of the head by an internal examination.
- Empty the bladder by catheterization.
- Infiltrate the perineum with local anesthesia.
- Give an episiotomy when the perineum becomes bulged and thinned out by the advancing head.
- Assess fetal heart rate frequently.
- Gynecologist identifies the forceps blades.
- Inserts four fingers of right hand along the left lateral vaginal wall, palmar surface of the fingers rest against the side of the fetal head.
- The handle of the left blade is taken in the left hand in a pen holding manner and is held vertically. The fenestrated portion of the blade is then introduced between the internal fingers and fetal head, manipulated by the left thumb.
- Introduction of the right blade is done after introducing two fingers of the left hand into the right lateral wall of the vagina along the side of baby's head. Right blade is introduced in the same manner as with the left one but holding it with the right hand.
- With the right blade over the left one the doctor articulates and locks the blades. In case of difficulty in locking, the blades are removed and reapplied. With correct application and locking is easy.
- During the next uterine contraction the doctor gives steady but intermittent traction.
- In outlet forceps, the traction may be continuous and contraction is not awaited as the head is already on the perineum.

- Once the head is crowned the direction of pull is gradually changed to upwards and forwards towards the mother's abdomen to deliver the head by extension.
- Once the bay's head is delivered, the blades are removed one after the other, the right one first.
- Further steps are to be followed as in normal vaginal; delivery. Intra venous Methergine is to be administered with the delivery of the anterior shoulder.
- Episiotomy is repaired in the usual manner.

Purpose:

Ventouse extraction is an instrumental delivery to facilitate a vaginal delivery. This mode of delivery is not appropriate for babies under thirty–four (34) weeks gestation. The delivery shall be performed by a registrar or a consultant. If three (3) attempts fail, the obstetrician shall consider another mode of delivery.

- Inform the Neonatologist/Pediatrician and alert the Operating Theatre staff.
- Ensure that the period of gestation isgreaterthan34 weeks.
- Choose the appropriate size cup that will fit the baby's head.
- Ensure that all available resuscitative equipment and supplies are functional.
- Ensure that no cervix or the vaginal wall is trapped beneath the rim of the cup.
- Establish gentle suction while the Patient continues to push during contractions.
- Perform episiotomy during the crowning of the head.
- Releasesuctionandremovecuponcetheheadisdeliveredandcompletedeliveryasnormal.
- Ensure that all care is documented accurately and in a timely manner.
- EnsurethatassessmentofvitalsignsaremadeandrecordedinthePatient'sMedicalRecord.
- Monitor and record
  - The Patient 's vital signs
  - Lochia
  - Coping patterns
- Follow established infection preventionand control guidelines according to HIC manual.

Definition

Assessing the state of uterus in the post delivery period as it returns to the pre-gravid state.

Purpose:

- To rule out infection
- To estimate the rate of at which involution takes place
- To assess the puerperal conditions of women who had complicated labor.

Procedure

- Explain the procedure to patient and instruct her as how she has to cooperate
- Arrange the unit and assemble necessary articles at bedside.
- Endure that patients bladder is empty
- Pull curtains / screen the bed.
- Position on the patient in supine and drape the patient exposing only the lower abdomen
- Don gloves.
- Locate funds with the palm of one hand
- Place lateral side of hands slightly above funds.
- Place your other hand above the symphysis pubis.
- Gently but firmly press into abdomen towards the spine and then slightly downwards towards the perineum until a mass is felt in the palm of the hand.

- Measure the number finger breath at which the fund is felt below the umbilicus with the help of an inch – tape measure from the level of funds to the upper border of symphysis pubis.
- With gloved hand check perineal pad for color of lochia.
- Offer perineal care if needed and provide a clean pad.
- Replace the articles and wash hands.
- Mark the fundal height in nurse record.

Definition

Dilation and curettage (D&C) is a procedure in which doctor removes the tissue from the inner side of the uterus.

Purpose

- To diagnose or treat various uterine conditions such as:
  - Heavy bleeding
  - To clear the uterine lining after a miscarriage or abortion.

Procedure:

- Explain the procedure to the patient.
- Obtain informed consent from the patient.
- Instruct patient to empty the bladder prior to operation.
- Maintain NPO for 6hours before procedure.
- Administer pre-medication as per physician's order.
- Start I.V line.
- Maintain lithotomy position and clean the perineum with Betadine solution.
- Gynaecologist introduces Sim's vaginal speculum inside the vagina.
- In nulliparous women the blade of the speculum is lubricated and introduced from the side of vaginal outlet after separating the labia minora with the other hand till the entire blade is introduced inside the vagina.
- In parous women, the blade is introduced on separating labia minora.
- The anterior tip of the exposed cervix is grasped by the toothed vulsellum and pulled down near the vaginal introitus.
- A uterine sound is introduced with the tip directed forward into uterus.
- Assist in dilation of the cervix. The tip dilator should be directed anteriorly or posteriorly according to the position of the uterus.

- After the desired dilatation the uterine cavity is curetted by uterine curette either in clockwise or anticlockwise direction in a smooth manner.
- Take out the vulsellum and curette.
- Clean the cervix with betadine solution and check for any unusual bleeding.
- The curetted materials are preserved in 10% normal saline, labeled properly and send for histological examination.
- Record the data and time of procedure with patient's reaction.

EQUIPMENTS REQUIRED

- Evacuation set
- Injection tray with

a) 5cc syringe-2

b) 20G needle-2

c) 22G needles-2

d) Injection oxyticin

e) Inj. Methergin-2 amp

f) Inj. Pethidine

- Betadine solution
- 5% Dextrose
- I.V stand
- Spot light
- Stirrups
- K-basin
- Delivery linen bundle containing:

a. Gown

b. Leggings

c. Delivery sheet

d. Surgical towels-2

e. Sterile gauze pieces

f. Cotton balls

g. Perineal pad

- Other articles like apron, mask, I.V cannula, sterile gloves and sterile delivery kit

PROCEDURE:

- Explain the procedure to the patient
- Ensure the written consent for procedure is obtained
- Encourage patient to empty bladder
- Provide privacy
- Assist doctor in starting intravenous infusion line and adding inj.Pitocin.
- Place the patient in lithotomy position by using stirrups
- Administer sedation as per order
- Provide adequate lighting
- Assist for evacuation
- Administer medications e.g., Inj. Methergine as per order.
- Give perineal care and fix sterile pad.
- Make patient lie down comfortable and replace equipment.
- Send specimen for histopathological examination.
- Observe for bleeding per vagina
- Check and document vital signs every 15 minutes for first one hour, every 30minutes for next hour, and hourly till stable.
- Keep patient in treatment room till Pitocin drip is over.
- Transfer the patient to ward as per order.
- Document time including starting and completing time, condition of the patient and evacuated specimen sent to pathology department.
- Report any excessive bleeding per vagina

Equipments required:

- sterile douche can with tubing and screw clamp
- sterile irrigating fluid as prescribed:
    a. boiled and cooled water (500-1000ml) or
    b. normal saline or
    c. antiseptic(15ml for 500ml)
    d. sterile spoon
- Sterile irrigation vaginal nozzle
- Sterile gloves
- Perineal care pack
- Mackintosh
- K-basin
- Bed pan
- Duster
- I.V stand

Procedure:

- Explain the procedure to the patient
- Instruct the patient to empty bladder
- Collect the equipments
- Provide privacy
- Place the patient in a modified lithotomy position and drape
- Wash hands
- Open sterile equipment
- Prepare solution as prescribed
- Check temperature of water
- Tighten screw clamp, pour solution in can
- Wear gloves

- Give perineal care
- Hang douche can on I.V stand height of can about 16-18 inch from perineum. Connect douche nozzle to the tubing
- Check patency of tube by running some solution in the K- basin
- Insert nozzle gently in to the vagina
- Rotate nozzle gently downward and backward
- Clamp tubing when solution is over; remove nozzle and place in K-basin
- Instruct patient to cough which will aid in draining fluid(discourage coughing in a patient with prolapsed uterus)
- Clean the perineum and make the patient comfortable.
- Replace equipment
- Document time, solution used, characteristics of return flow and any significant observations
- Report any significant observation to doctor.

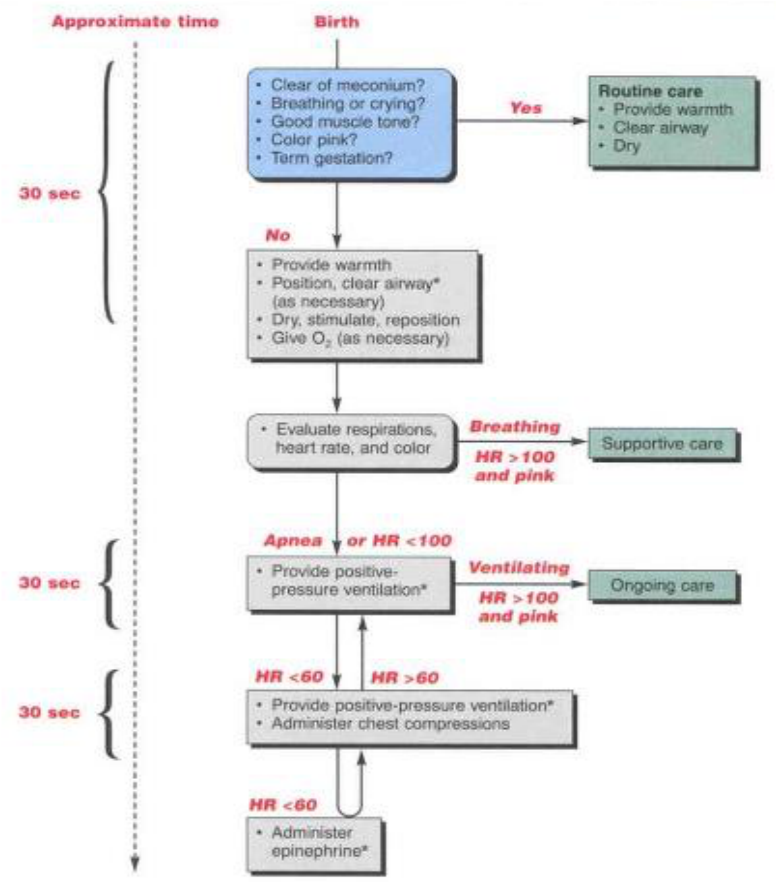
Procedure

- Soon after delivery place the baby in a tray lined with sterile linen with the head slightly upward.
- Clear the air passage using mucous extractor or bulb mucous sucker.
- Check Apgar score rating 1 minute and 5 minute and record it
- Clamp and cut the cord. Cord is to be clamped, divided and examined following birth of the baby.
- Dry the baby thoroughly, remove the linen and wrap the baby in dry, warm blanket/sheet.
- Tie identification tags which have mother's name, sex, time of birth and hospital number on ankle of the baby.
- Apply cord clamp and cut the cord shorter to desirable length **(3-5 cm away from the umbilicus)**
- Place the baby under a radiant warmer until temperature is stable.
- Check patency of rectum by introducing lubricated rectal thermometer.
- Clothe the baby using a dress that is appropriate for the climate.
- Extremities should be free for movement. Apply a napkin which should be changed periodically.
- Check the weight and length of the baby, the baby should be weighed naked.
- Administer vitamin K, 1 mg I.M
- The baby should be covered well, including the head.
- As the baby is usually alert in the 30-60 minuts after birth, he should be handed over to the mother as soon as possible.
- At this point, every attempt should be made to suckle the baby at the mother's breast.
- Identification should be crosschecked with the postnatal ward staff, before handing over the baby.

EQUIPMENTS:

- Radiant warmer
- Oxygen
- Suction Apparatus
- Clock timer
- Straight blade laryngoscope (0,1)
- ET tubes 2.0mm, 2.5mm, 3mm, 3.5mm
- Suction catheter size 6, 8 and 10 F
- Neonatal bag and mask
- Stethoscope
- Warmed dry towel

Procedure


Approximate time
Birth
• Clear of meconium?
• Breathing or crying?
• Good muscle tone?
• Color pink?
• Term gestation?
Yes
Routine care
• Provide warmth
• Clear airway
• Dry
30 sec
No
• Provide warmth
• Position, clear airway* (as necessary)
• Dry, stimulate, reposition
• Give O_2 (as necessary)
• Evaluate respirations, heart rate, and color
Breathing
HR >100 and pink
Supportive care
Apnea or HR <100
30 sec
• Provide positive-pressure ventilation*
Ventilating
HR >100 and pink
Ongoing care
HR <60
HR >60
30 sec
• Provide positive-pressure ventilation*
• Administer chest compressions
HR <60
• Administer epinephrine*

Purpose:

The Breech delivery is considered an abnormal delivery; the management plan for the Patient with a breech presentation is aimed at ensuring an uneventful delivery of a healthy infant with little or no adverse life threatening conditions. Close monitoring is very important; once vaginal delivery is confirmed, progress is monitored with two (2)hourly vaginal examinations.

Procedure

- Conduct an abdominal examination and document findings in the Patient's health record.
- Performasterilevaginalexaminationto(a)assesscervicaldilation(b)confirmthepresentingpartand(c)exclude cord presentation/prolapse.
- Inform the on-call Obstetrician of the findings of the abdominal and vaginal examination.
- InformtheOperatingtheatre,AnesthetistandNeonatologist/Pediatricianofthependingdelivery.
- Discuss the plan of care with the Patient to facilitate her active participation.
- Employ pain management in accordance with written protocols and procedure.
- Conduct continuous electronic fetal monitoring during the labour.
- Collaborate with the Obstetrician to determine the appropriate mode of delivery after confirming the presentation.
- Provide support and guidance to the Patient throughout the delivery process.
- In the absence of the obstetrician, the Nurse/ Midwife shall perform the breech delivery.
- Ensure that the Obstetrician and Neonatologist/ Pediatrician are present at a breech delivery.
- Follow established infection prevention and control guidelines according to HIC manual.

Purpose:

Shoulder Dystocia is the impaction of the fetal shoulders against the pubis. It is a delivery that requires additional maneuvers to deliver the shoulders. If not dealt with expeditiously fetal death can occur. The obstetrician must be informed as soon as the problem is recognized.

WARNING SIGNS FOR SHOULDER DYSTOCIA:

- Difficulty with birth of the face and chin
- The fetal head retracts against the perineum. Referred to as the 'turtle' sign.
- Failure of the fetal head to restitute.
- Failure of the shoulders to descend.

Procedure

- Recognize the problem and call for assistance.
- Call Consultant, the anesthetist and paediatrician.
- Note the time of delivery of the head.
- Explain the procedure tot he Patient to gain her cooperation.
- Explain the procedure to the Patient including the inherent risks and obtain informed consent.
- Avoid fundal pressure and extensive traction on the fetal neck.
- Perform an episiotomy if possible.
- Conduct the **Mc Roberts maneuver.**
- Attempt different maneuvers to deliver the baby and if all else fails then **Zavannelli maneuver** should be considered
- Apply suprapubic pressure over the fetal anteriors houlder.
- Attempt to deliver the posterior shoulder.
- Ensurethepediatricianispresentforthedeliveryaswellasensuringthatresuscitativeequipment is present and functional.

DOCUMENTATION:

Signs & symptoms

- Time head delivered & when the shoulder dystocia identified

- Direction the head was facing or position after restitution(e.g: Left occiputo anterior)

Interventions

- When doctor/ gynecologist called and time arrived
- Staff in attendance and time they arrived
- Time, sequence, and description of each maneuver used
- Time of episiotomy, if performed
- Time of bladder catheterization, if performed
- Time the baby delivered

Responses

- Results with each maneuver used
- The condition of the newborn (NRP required, APGAR Score)
- Results of cord blood gases
- The condition of the mother

Abruptio placenta is premature separation of the normally implanted placenta before the birth of the foetus.

Classification:

Partial : partial abruption with concealed bleeding

Marginal: marginal abruption with external bleeding

Complete: complete abruption with concealed bleeding

Management:

- Monitor maternal vital signs and foetal heart rate
- Assess for excessive vaginal bleeding , abdominal pain and increase in the fundal height
- Maintain bed rest, administer oxygen, IV fluids and blood products as prescribed
- Place the client in trendelenburg's position, if indicated to decrease the pressure of the foetus on placenta.
- Monitor and report any uterine activity
- Prepare for delivery of the foetus as quickly as possible, with vaginal delivery preferably if the the foetus is healthy and stable and presenting part is in the pelvis
- Establish and maintain large bore I.V line for fluids.
- Investigations like BT, CT, grouping and RH typing, LFT, APTT, PT, INR (International Normalized Rate) to be done.
- Inform the doctor and evaluate maternal and fetal condition and an abdominal USG may be taken if necessary.
- Explain the condition of the mother, foetus and plan for the surgery to the patient's relatives.
- Keep the patient NPO
- Emergency cesarean delivery is performed if the foetus is alive but shows signs of

distress

- Informed high risk consent and procedure consent are taken if there is requirement for surgery.
- Inform the anesthetist, OT staff and the Pediatrician.
- Administer pre- operative medication as ordered.
- Skin preparation is done and the mother is prepared for surgery.
- Record all details in the patient's file.
- Transfer the patient to the O.T for surgery and all information and records are handed over to O.T.

a. Description:

- Placenta previa is an improperly implanted placenta in the lower uterine segment near or over the internal cervical os

b. Assessment:

- Sudden onset of painless, bright red vaginal bleeding occurs in the last half of pregnancy
- Uterus is soft, relaxed and nontender.
- Fundal height may be more than the expected for gestational age.

c. Intervention:

- Monitor maternal vital signs, foetal heart rate and fetal activity
- Prepare for ultrasound for confirmation
- Vaginal examination or any other action that would stimulate uterine activity are avoided
- Maintain bed rest in side lying position as prescribed
- Monitor amount of bleeding
- Administer intravenous fluid, blood products or tocolytic medication as prescribed
- If bleeding is heavy a cesarean delivery may be performed .

Procedure

a. Intervention for mild preeclampsia:

- Provide bed rest and place the client in the lateral position
- Monitor blood pressure and weight
- Monitor neurological status because changes can indicate cerebral hypoxia or seizure
- Monitor deep tendon reflexes
- Provide adequate fluids
- Monitor intake and output, urine output of 30ml/hr
- Increase dietary protein and carbohydrate and no added salt
- Administer antihypertensive as prescribed
- Monitor for HELLP syndrome(H: Hemolysis, E L: Elevated Liver enzyme, L P: low platelet count)

b. Intervention for severe preeclampsia:

- Maintain bed rest
- Administer magnesium sulfate as prescribed to prevent seizure
- Monitor magnesium toxicity including sweating , hypotension, depressed deep tendon reflex, central nervous system depression, respiratory depression, keep antidote calcium gluconate at patient side
- Administer antihypertensive as prescribed
- Prepare for induction of labor

ECLAMPSIA :

is the onset of seizures (convulsions) in late pregnancy which occur as a result of being pregnant. These seizures are tonic–clonic, life-threatening, and usually preceded earlier in the pregnancy by the appearance of an elevated blood pressure, protein in the urine, and edema, a condition called pre-eclampsia. Pre-eclampsia and eclampsia are also called hypertensive disorder of pregnancy and pregnancy induced hypertension.

GENERAL MEASURES:

- The woman should be managed in a quiet, well lit room in a high dependency care type situation. Ideally there should be one to one midwifery care.
- All treatments should be recorded.
- The consultant obstetrician on duty should be informed, so that they can be involved at an early stage in management.
- Basic Investigations Blood should be sent for: Serum electrolytes• Liver function tests• Full Blood count• Clotting• Group and save serum
- All tests should be checked daily or more frequently if abnormal.
- vital signs should be measured every 15 minutes until stabilised and then half hourly.
- An indwelling catheter should be inserted and urine output measured hourly whenever intravenous fluids are given.
- Oxygen saturation should be measured continuously and charted with the blood pressure. If saturation falls below 95% then medical review is essential.
- Fluid balance should be monitored very carefully. Detailed input and output recordings should be charted.
- Fetal well-being should be assessed carefully..
- Total input should be limited to 80ml/hour.
- The drugs, to reduce the blood pressure to 160mmH are labetalol ,hydralazine and nifidipine. It is appropriate to treat cases of severe pre-eclampsia with Magnesium Sulphate to prevent seizures.

MAGNESIUM SULPHATE PROTOCOL

Magnesium sulphate is given as a loading dose followed by a continuous infusion for 24 hours or until 24 hours after delivery . The loading dose is 4g magnesium sulphate i.v. over 5 -10 minutes. The maintenance dose is 1g magnesium sulphate i.v per hour. Side effects Motor paralysis, absent tendon reflexes, respiratory depression and cardiac arrhythmia (increased conduction time) can all occur but will be at a minimum if magnesium is administered slowly and

the woman is closed monitored. Important observations formal clinical review should occur at least every 4 hours. Continuous pulse oximetry (alert Anaesthetist if O2 sat< 12/min. The antidote is 10ml 10% calcium gluconate given slowly intravenously. 97% of magnesium is excreted in the urine and therefore the presence of oliguria can lead to toxic levels . In the presence of oliguria, further administration of magnesium sulphate should be reduced or withheld. Magnesium should be reintroduced if urine output improves. Prepare for induction of labour.

DEFINITION

Antepartum haemorrhage is defined as bleeding from the vagina after the twenty-eighth week of pregnancy and before the birth of the baby. It is a life threatening condition in pregnancy which if not addressed with urgency can lead to the death of both mother and infant. Causes include placenta previa and placental abruption.

Procedure

The Nurse shall:-

- Manage the care of the Patient utilizing the Nursing Process.
- Inform the Patient and significant other on the Patient's condition and allay any fears.
- Inform immediately the Obstetrician on duty of the presence of the Patient with ante-partum haemorrhage.
- Obtain a history from the Patient as detailed as possible.
- Conduct a gentle abdominal palpation to identify the fetal position.
- Institute bed rest until otherwise advised by the attending Obstetrician.
- Obtain a specimen of urine for testing and catheterize if necessary.
- Commence CTG and EFM monitoring to assess fetal heart rate and report findings.
- Monitor the vital signs as required and take the appropriate action.
- Observe for signs of impending shock.
- Monitor the Patient for increased vaginal bleeding.
- Ensure an IV access is established and administer appropriate intravenous fluids if blood loss is severe.
- Withhold performing a vaginal examination so as to minimize the risk of severe hemorrhage.

The **Obstetrician** shall:-

- Explain to the Patient and significant other the nature and risks involved in the existing situation.
- Utilizetherelevanttechnologythatwillassistintheconfirmationofdiagnosisandtreatment.
- Administer the appropriate intravenous fluids if blood loss is severe.
- Obtain the relevant blood samples for testing to assist in the diagnosis and treatment.
- Obtain an informed consent from the Patient in the event there is need to perform an emergency Caesarean Section.
- Evaluate the Patient 's progress and revise the plan of care as necessary.

Purpose:

Pre-labour rupture of membranes with the presenting part not engaged presents a risk to the infant. The infant can be exposed to the risk of (a)infection (b)cord prolapse (c)fetal distress. If this situation is not addressed as a matter of urgency,death to the fetus may result.

Procedu re

- Manage the care of the Patient utilizing the nursing process.
- Take a complete history from the Patient, noting the date and time of rupture.
- Explain to the Patient and significant other the nature and risks involved in the existing situation and attempt to allay fears.
- Conduct a complete abdominal examination of the Patient.
- Assess the volume, colour, odour and consistency of the liquor.
- Prepare the Patient for a speculum vaginal examination.
- Monitor vital signs as often as required noting temperature variations.
- Monitor fetal heart rate every two (2) hours or as prescribed by the Obstetrician.
- Ensure the Patient maintains a “kick” count chart.
- Utilize the relevant technology to assist with monitoring the fetal heart rate.
- Utilize the relevant technology to assist in diagnosis and treatment of the Patient
- Obtain the relevant blood samples for testing to assist in the diagnosis and treatment.
- Develop a detailed plan of care for the Patient.
- Inform Patient or significant other of the plan of care and obtain consent where applicable.
- Prescribe the appropriate antibiotic where appropriate.
- Evaluate the Patient’s progress and revise the plan of care is necessary.

Purpose:

The Prolapsed Cord is usually felt as a soft loop lying beside or in front of the presenting part, when the membranes have been ruptured. It will pulsate if the fetus is still alive. This is a life threatening situation for the fetus and it is important that the infant be delivered with in the shortest possible time.

Procedure

- Assist and support the Patient in position (exaggerated Sims) to prevent cord compression.
- Determine fetal viability using appropriate technology.
- Provide the Patient with the necessary support and information to gain her cooperation.
- Conduct a vaginal examination to determine (a) the degree of cervical dilatation,(b)the presenting part and (c) cord pulsation.
- Apply sterile gauze moistened with warm saline on cord if appropriate.
- Establish an IV access and keep Patient nil per oral route (NPO).
- Monitor and record the health status of the fetus using the appropriate technology.
- Inform the Obstetrician, giving details of the obstetric history and present findings.
- If there is no cord pulsation, and no fetal heart is heard, spontaneous vaginal delivery is allowed.
- If cord pulsation is felt and fetal heart is heard, prepare Patient for delivery via Caesarean Section or vaginal delivery as appropriate.
- In the event of fetal demise, provide emotional support to the Patient and significant other and refer for bereavement counselling and monitor/follow up.

Purpose:

Obstetric haemorrhage remains one of the major causes of maternal death in both developed and developing countries. Postpartum hemorrhage is defined as excessive bleeding from the genital tract occurring any time from the time of the birth to the end of the puerperium. PPH could be described as minor if there is a blood loss of 500–1000 mls or major with a blood loss of over 1000 mls. There is need to manage this condition actively since failure to treat in a timely manner, will be life threatening.

Procedure

- Inform the Consultant and the Anesthetist.
- Determine the cause of the hemorrhage – uterine atony, trauma to the tissues, retained placenta or products, DIC.
- Obtain blood for CBC, clotting screen, Group & Cross Match, RFT, LFT.
- Ensure an intravenous access and infusion is established.
- Place Patient in a supine position and maintain warmth.
- Examine the placenta for completeness.
- Examine the abdomen to establish uterus is contracted.
- Stimulate the abdomen to ensure contraction of the uterus.
- Administer Oxytocic agents e.g. Syntocinon, Carbetocin, Misoprostol asprescribed.
- Ensure that a urinary catheter is inserted and attached to a closed drainage system.
- Measureand record the blood loss.
- Assess and record the vital signs of the Patient.
- Make Patient comfortable and allay her fears.

High Risk Pregnancy is a pregnancy which can create challenges for a satisfactory outcome for the Patient with an underlying. Medical condition or a Patient who is at risk for developing complications of pregnancy.

A.Rupture of uterus

a. Description:

- Complete or incomplete separation of the uterine tissue as a result of a tear in the wall of the uterus from the stress of labor.
- Complete: direct communication between the uterine and peritoneal cavity
- Incomplete: rupture in the peritoneum covering the uterus but not into the peritoneal cavity.

b. Assessment:

- Abdominal pain or tenderness
- Chest pain
- Contraction may stop or fail to progress
- Rigid abdomen
- Absent foetal heart rate
- Signs of maternal shock
- Foetus palpated outside the uterus (incomplete rupture)

c. Intervention:

- Monitor for the signs of shock and administer oxygen, IV fluids, blood products as prescribed
- Prepare client for cesarean delivery(possible hysterectomy may be necessary)
- Provide emotional support for patient and partner

B.Amniotic fluid embolism

a. Description:

- Amniotic fluid embolism is the escape of amniotic fluid in the maternal circulation

- The debris contaminating amniotic fluid deposits in the pulmonary arterioles and usually fatal to the mother.

b. Assessment:

- Abrupt onset of respiratory distress and chest pain
- Cyanosis
- Seizure
- Heart failure and pulmonary edema
- Foetal bradycardia and distress

c. Intervention

- Keep ready resuscitation tray
- Administer oxygen 8-10 L/min by face mask or resuscitation bag delivering 100% oxygen
- Prepare for intubation and mechanical ventilation
- Position the patient on her side
- Administer IV fluids, blood products and medication to correct coagulation failure
- Monitor fetal status
- Prepare for emergency delivery when the client is stabilized
- Provide emotional support to the patient, partner and family

C.Cord prolaps

a. the umbilical cord is displaced between the presenting part and the amnion or protruding through the cervix, causing compression of cord and compromising fetal circulation

b. Types of cord prolaps:

- occult prolaps of cord
- complete prolaps of cord with membrane intact
- cord presentation
- frank breech presentation with prolapsed cord

c. Assessment:

- the client has the feeling that something is coming out through the vagina
- umbilical cord is visible or palpation
- fetal heart rate is irregular and slow
- fetal monitoring shows variable declarations or bradycardia after rupture of the membrane

d. Intervention:

- evaluate foetal presenting part that is lying on the cord by applying figure pressure with a glove hand
- place the client in extreme trendelenburgs or modified Sims position or a knee chest position
- administer oxygen 8 to 10 l/min by face mask to patient
- monitor foetal heart rate and assess foetal hypoxia
- Prepare to start IV solution.
- Document the event, action taken and the client's response.

It is a life threatening condition that is characterized by failure of the circulatory system to maintain adequate perfusion of the vital organs, resulting in cellular hypoxia.

Causes:

Haemorrhagic shock: It is associated with blood loss.

- Bleeding in early pregnancy(abortion, ectopic or molar pregnancy)
- bleeding in late pregnancy or labor(placenta previa, abruptio placenta, ruptured uterus)
- bleeding after child birth(ruptured uterus, uteric atony, tears of genital tract, retained placenta or placental fragments)
- trauma (injury to uterus and bowel during abortion, ruptured uterus, tears of genital trat, vesicular accidents, falls, assaults or penetrating injuries.)

Septic shock: it is associated with

- Septic Abortion
- Chorioamniotic and Post Partum Infections
- Pyelonephritis and Respiratory Tract Infection.

Other causes such as

- Cardiogenic Shock
- AF Embolism Or Pulmonary Embolism

Diagnosis:

- fast, weak pulse(110 per minute or more)
- low B.P (systolic <90mm Hg)
- pallor(especially lower eyelid, palms or around mouth)
- increased sweating(rate of 30 beats/min and more)
- anxious, confusion or unconsciousness
- scanty urine output(<30ml/hr)

Management:

- Measure to resuscitate the patient
- Treat Underlying Causes
- Prevent Complication

Immediate Management:

- monitor vital signs
- turn the woman into her side to minimize the risk of aspiration
- keep the woman warm
- evaluate her legs to increase return of blood to the heart(if possible raise the foot end of the bed)
- Specific Management:
- start I.V infusions using 16G cannula
- blood test like Hb, crossmatching, CT
- infuse I.V fluids(NS/RL) rapid infusion as the rate of 1L in 15- 20 minutes
- monitor vital signs every 15 minutes
- catheterize the bladder to monitor I/O chart.
- Give O2 at the rate of 6-8L/mt by face mask.