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# Casebook of Midwifery/Obstetrics and Gynecology Nursing

## As per the Revised INC Syllabus for BSc Nursing Semesters VI and VII

**Name of the Candidate:** _____

**Name of the Institution:** _____

_____

**Rekha Kumari**
**R Sreeraja Kumar**

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# INC Requirement for BSc Nursing-Semesters VI and VII for Midwifery/Obstetric and Gynecology NURSING I and II

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# ANTENATAL EXAMINATION

## INTRODUCTION

Antenatal care is crucial for ensuring a healthy pregnancy and the well-being of both the mother and baby. This care should begin as early as the first trimester and continue consistently throughout the second and third trimesters.

### Purpose

- To promote, protect, and sustain the health of the mother throughout pregnancy.
- To identify high-risk pregnancies and provide specialized care to prevent complications.
- To detect and address any abnormalities in pregnancy as early as possible.
- To educate mothers on proper prenatal care.
- To prepare mothers for newborn care and support early, exclusive breastfeeding.

### Articles

| *S.No.* | *Article* | *Rationale* |
|---|---|---|
| 1. | Handwashing articles | To ensure hygiene |
| 2. | Cot for the community | To provide comfort and support during procedures |
| 3. | Sheet for the mother | To maintain privacy |
| 4. | Weighing machine | To monitor weight |
| 5. | Measuring tape | To take necessary measurements |
| 6. | Vital signs equipment | To assess baseline health data |
| 7. | Torch | To facilitate visualization |
| 8. | Kidney tray | To manage waste and collect waste products |
| 9. | Sterile pack | To perform procedures in a sterile environment |

### Procedural Steps

1. **Check vital signs:** Begin by measuring the mother's vital signs.
2. **Position of the mother:** Ask the mother to lie down and cover herself with a sheet up to the neck for privacy. Conduct the assessment under the following categories:
   - *Head:*
     - Observe the color of the hair.
     - Make creases on the scalp and check for dandruff and lice.
   - *Eyes:*
     - Gently pull down the lower eyelid with your right index finger and ask the mother to look up.
     - Note the color of the conjunctiva and sclera.
     - Check for any discharge, dryness, signs of vitamin A deficiency or infection.
   - *Ears:*
     - Hold the lower part of the pinna and gently stretch it downward.
     - Examine for any discharge, growth or wax accumulation.
   - *Nose:*
     - Pinch the tip of the nose and gently stretch it upward.
     - Inspect for nasal discharge.

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- *Mouth:*
  - Ask the mother to open her mouth and slightly stick out her tongue.
  - Check for dryness, angular stomatitis, dental caries, foul smell, overall hygiene and missing teeth.
- *Face:*
  - Assess for chloasma gravidarum (pregnancy-related pigmentation).

### *Neck Examination*

Keep both hands on the neck, gently pressing with the web of your fingers to palpate for any enlarged lymph nodes.

### *Axillary Examination*

Use the web of your fingers to gently press and check the axilla for any enlarged lymph nodes.

### *Breast Examination*

- Palpate the breast in a circular motion to detect any lumps or areas of hardness.
- Examine the primary and secondary areola, including any tubercles.
- Inspect the nipples for milk secretion, cracks or depression.

### *Perineal Examination*

- Ask the mother about any vaginal discharge or itching.
- Assess the discharge for color, odor, and amount.

### *Lower Extremity Examination*

- Check for pedal edema by pressing the inner ankle with your thumb for about 2 seconds.
- Palpate the calf of the legs to check for varicose veins.
- Observe any distended veins.

### *Abdominal Examination*

#### Abdominal Girth

- Locate the top of the pubic bone and find the top of the uterus by palpation, potentially with a deep breath.
- Start the tape measure at the top of the pubic bone, typically at the level of the belly button and measure to the top of the uterus.
- Note the measurement in centimeters.

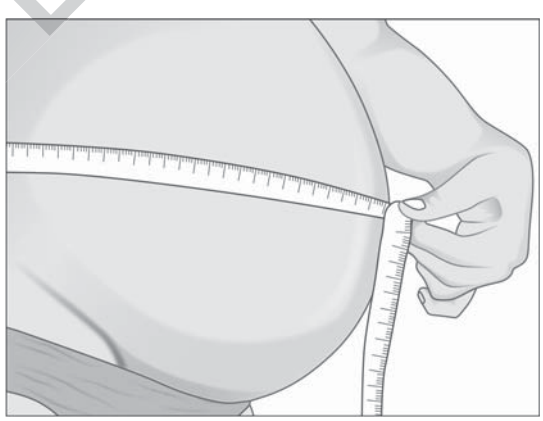

**Fig. 1:** Measuring abdominal girth.

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### Fundal Palpation

- For fundal palpation, stand facing the patient's head and use the tips of both hands' fingers to palpate the uterine fundus.

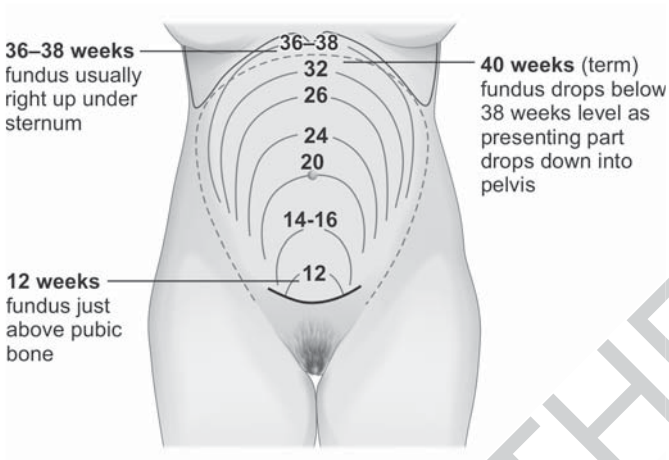


**Fig. 2:** Measuring fundal height.

- When the fetal head is in the fundus, it will feel like a smooth, hard, globular, mobile, and ballotable mass.
- If the breech is in the fundus, it will be perceived as a soft, irregular, rounded, and less mobile mass.

### Lateral Palpation

- Stand facing the patient's head and place your hands on either side of the abdomen. Use one hand to steady the uterus and with the other, palpate the opposite side to determine the location of the fetus's back.

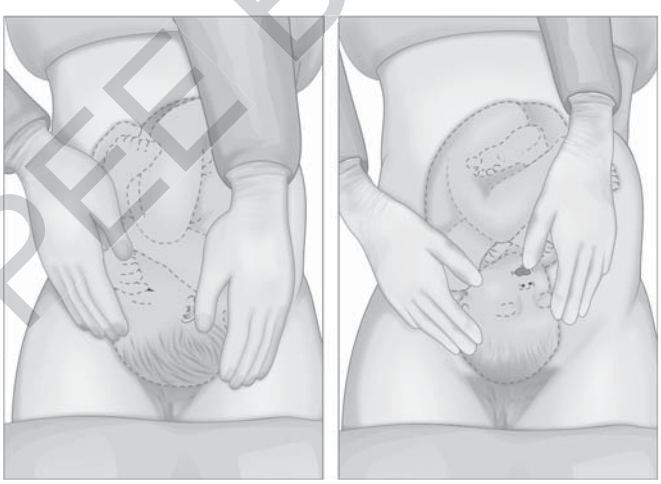

**Fig. 3:** Lateral palpation.

- The fetal back will feel firm.
- Smaller parts, such as the hands, arms, and legs, will feel like irregular masses and may be either actively or passively mobile.

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### Pelvic Palpation

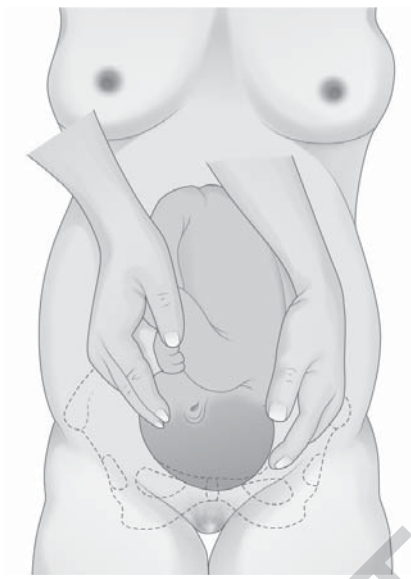

**Fig. 3:** Pelvic palpation.

- During this grip, face the patient's feet.
- Gently slide your fingers down the sides of the abdomen towards the pelvis until one hand encounters a bony prominence.

### Pawlick's Grip

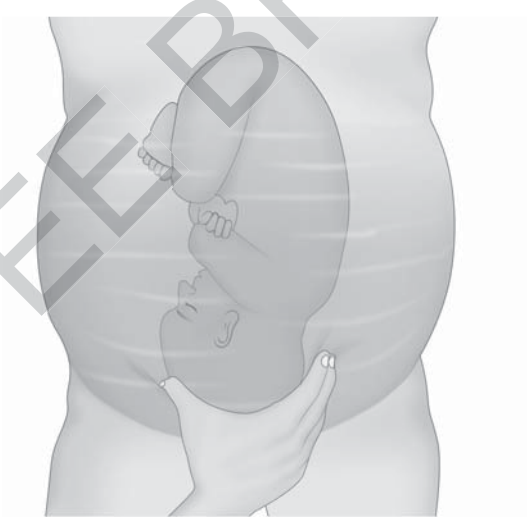

**Fig. 5:** Pawlick's grip.

- Place the tips of the first three fingers of each hand on either side of the abdomen, just above the symphysis pubis. Instruct the patient to take a deep breath and then exhale.
- As the mother exhales, gently and gradually press your fingers down around the presenting part.
- Auscultate the fetal heart sound (FHS) using a stethoscope. The maximum intensity of the FHS is typically heard below the umbilicus in a cephalic presentation and around the umbilicus in a breech presentation.

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# INTRANATAL CARE

## CARE OF MOTHER IN LABOR

### Introduction

Normal labor and delivery are natural physiological process, involving rhythmic contractions that work to expel the products of conception. The first stage of labor begins with the onset of true labor pain and concludes with full cervical dilation. Care for the mother starts as soon as true labor pain is recognized. It is the midwife's responsibility to confirm that true labor has begun before proceeding. The mother may report any of the following signs:

- Onset of regular, progressive uterine contractions that increase in frequency, strength, and duration.
- Blood-tinged vaginal discharge (show).
- Fluid discharge from the vagina.

## ADMISSION AND ASSESSMENT OF THE MOTHER DURING LABOR

Once true labor has been confirmed, the midwife performs a thorough assessment, which include interview, physical examination, and review of the prenatal records. These records provide essential baseline information about the mother.

### Purposes

- To prepare the mother for a safe delivery.
- To induce or augment labor, if necessary.
- To monitor mothers at high risk.
- To monitor the condition of both the mother and the fetus.

### Articles and their Rationale

| *S.No.* | *Articles* | *Rationale* |
|---|---|---|
| 1. | Soap solution | To wash hands and maintain hygiene |
| 2. | Gauze pieces | To clean and prepare the area for procedures |
| 3. | Razor with blade | To remove hair while preparing the area for cleanliness |
| 4. | Enema | To empty the bowel before delivery |
| 5. | Kidney tray | To collect waste during procedures |
| 6. | Vital signs tray | To measure temperature, pulse, respiration, and blood pressure |
| 7. | Clean gloves and patient records | To prevent infection and document findings |

### General Examination

#### *Admission Criteria*

- Admit women presenting with contractions, vaginal leaking or bleeding, reduced or absent fetal movements, or those less than 32 weeks gestation with pregnancy-induced hypertension or heart disease.
- Isolate women with infectious diseases, HIV-positive status, or HBSAg-positive status to prevent cross-contamination.
- For referred patients, ensure that the referral letter is placed on top of the patient's folder for easy access by the physician.

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- Contraindications for giving an enema:
  - Severe pregnancy-induced hypertension
  - Preterm labor
  - Cardiac diseases
  - Vaginal bleeding
  - Decreased fetal movements
  - Vaginal leaking
  - Grand multipara
  - Malpresentation
  - Women in the second stage of labor

### *Steps and Rationales*

| *S.No.* | *Steps* | *Rationale* |
|---|---|---|
| 1. | Welcome the mother to the unit. | A warm greeting creates a welcoming atmosphere and reassures the mother. |
| 2. | Collect the necessary history and reason for admission. | Helps in understanding the patient's condition and needs. |
| 3. | Explain all procedures to the patient and her relatives. | Ensures cooperation and understanding from the patient. |
| 4. | Assist the mother in changing into a hospital gown and handover her valuables to family members or relatives. | Prevents the loss of valuables and prepares the mother for medical procedures. |
| 5. | Collect samples needed for investigations, such as blood and urine. | Aids in diagnosing any complications. |
| 6. | Measure the mother's height and weight. | Provides baseline data for further assessments. |
| 7. | Check her vital signs. | Offers information on the patient's general condition. |
| 8. | **Information to Collect from the Patient:**<br>• Whether the mother is booked or unbooked.<br>• Obstetrical score.<br>• Gestational age.<br>• Any vaginal bleeding or leaking.<br>• Time of onset of labor contractions.<br>• Fetal movements.<br>• Any other complaints. | Collecting information is essential for planning the appropriate line of treatment. |
| 9. | **Physical Examination:**<br>Conduct thorough abdominal examination, including inspection, palpation, auscultation of fetal heart sounds, and monitoring of contractions. | Helps identify any deviations from normal conditions. |
| 10. | **Vaginal Examination:**<br>Check for cervical dilation, effacement, station, pelvic adequacy, membrane condition, head position, and degree of flexion. | Provides information about the progress of labor. |
| 11. | **Preparation for Delivery:**<br>Shave the pubic area using a razor, depilatory cream or clippers. | Helps prevent infection and allows clear visualization during delivery. |
| 12. | Administer an enema unless contraindicated by the physician. | Prevents contamination by fecal matter during the bearing-down phase. |
| 13. | **Documentation and Communication:**<br>Record the time of admission, reason for admission, assessment findings and procedures performed. | Facilitates communication among staff members about the patient's condition. |
| 14. | Instruct the patient to lie on the assigned bed in the labor room and inform the treating physician about the admission. | Ensures the patient is comfortable and the physician is aware of the situation. |
| 15. | **Emotional Support:**<br>Provide emotional support to the mother. | Helps in offering psychological reassurance during labor. |
| 16. | **Monitoring Labor Progress:**<br>Monitor the progress of labor using a partograph. | Assists in tracking labor status and preventing complications. |

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| | | |
|---|---|---|
| 17. | Teach relaxation techniques and breathing exercises. | Helps reduce discomfort for the mother. |
| 18. | Advise the mother to take plenty of fluids and eat a soft diet. | Prevents dehydration. |
| 19. | Check for signs and symptoms of dehydration. | Detects early signs of maternal exhaustion. |
| 20. | Administer 500 mL of Ringer lactate solution to maintain hydration status. | Ensures the mother stays adequately hydrated. |
| 21. | Position the mother in a left lateral position or encourage brisk walking if she prefers. | Prevents supine hypotension syndrome. |
| 22. | Encourage the mother to empty her bladder frequently. | A full bladder can impede the descent of the fetal head, so regular bladder emptying is essential. |

## After Care

Observation, Recording, and Reporting: Monitor maternal and fetal conditions regularly.

## Maternal Condition

- Conduct a general examination, check vital signs every two hours, monitor urine quantity and the presence of acetone, and observe the tongue for moisture (hydration status).
- Watch for abnormal signs and symptoms such as bleeding, epigastric pain, or abdominal discomfort.
- Assess uterine contractions for duration, intensity, frequency and nature, as well as cervical dilation and fetal head descent.

### *Signs and Symptoms of Maternal Distress*

- An anxious appearance with sunken eyes.
- Dry tongue.
- Acetone-smelling breath.
- Pulse rate above 100.
- Hot and dry vagina with an offensive discharge.
- Scanty, dark-colored urine with acetone.

## Fetal Conditions

- Observe for fetal well-being by checking the fetal heart rate (FHR):
  - **Rate:** 110-160 beats per minute.
  - **Rhythm:** The first beat should be short, and the second beat long.
- Look for signs of fetal distress, such as changes in heart rate (tachycardia or bradycardia) that may indicate cord compression, true knots, drug effects, anemia, antepartum hemorrhage (APH), or preterm labor.
- Meconium-stained discharge may indicate fetal distress due to a loose sphincter.

## Other Methods

- ECG tracing
- Amnioscopy
- Fetal blood pH: A pH greater than 7.2 may suggest fetal distress.

## Health Education

- Explain the progress of labor.
- Teach relaxation techniques, emphasize the need for rest and sleep, and provide pain relief methods.
- Instruct the mother on how to bear down effectively during the second stage of labor, including holding her breath, flexing her legs, taking deep breaths, and bearing down at the anus.
- Discuss about diet during the second stage.
- Emphasize the importance of personal and environmental hygiene.

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# MONITOR THE PROGRESS OF LABOR

## PARTOGRAPH

### Introduction

The partograph is an essential tool that acts as an "early warning system," helping healthcare providers make timely decisions regarding the transfer, augmentation and termination of labor. It enhances the quality and consistency of observations on both the fetus and the mother during labor, allowing for early detection of any complications.

### Definition

The partograph is a graphic representation of the events of labor plotted against time in hours, as defined by the World Health Organization (WHO).

### Objectives

- To provide a comprehensive overview of labor progress at a glance.
- To detect deviations from the normal duration of labor, enabling timely intervention.
- To facilitate the handover process between healthcare providers.
- To aid in managing prolonged labor and cesarean sections, thereby contributing to the improvement of maternal mortality rates and reducing fetal morbidity and mortality.

### Principles of Partograph

- The active phase of labor begins when the cervix is dilated to 4 cm.
- The latent phase of labor should not exceed 12 hours in primigravida and 8 hours in multigravida.
- A lag time of 4 hours between a slowdown in labor and the need for intervention is advisable to prevent compromising the fetus or mother while avoiding unnecessary interventions.
- Vaginal examinations should be performed in accordance with safe practice, with a recommendation of once every 4 hours.
- It is preferable to use a partograph with pre-set lines for clarity, though too many lines may cause confusion.

### Component of Partograph

- Fetal condition
- Progress of labor
- Maternal condition

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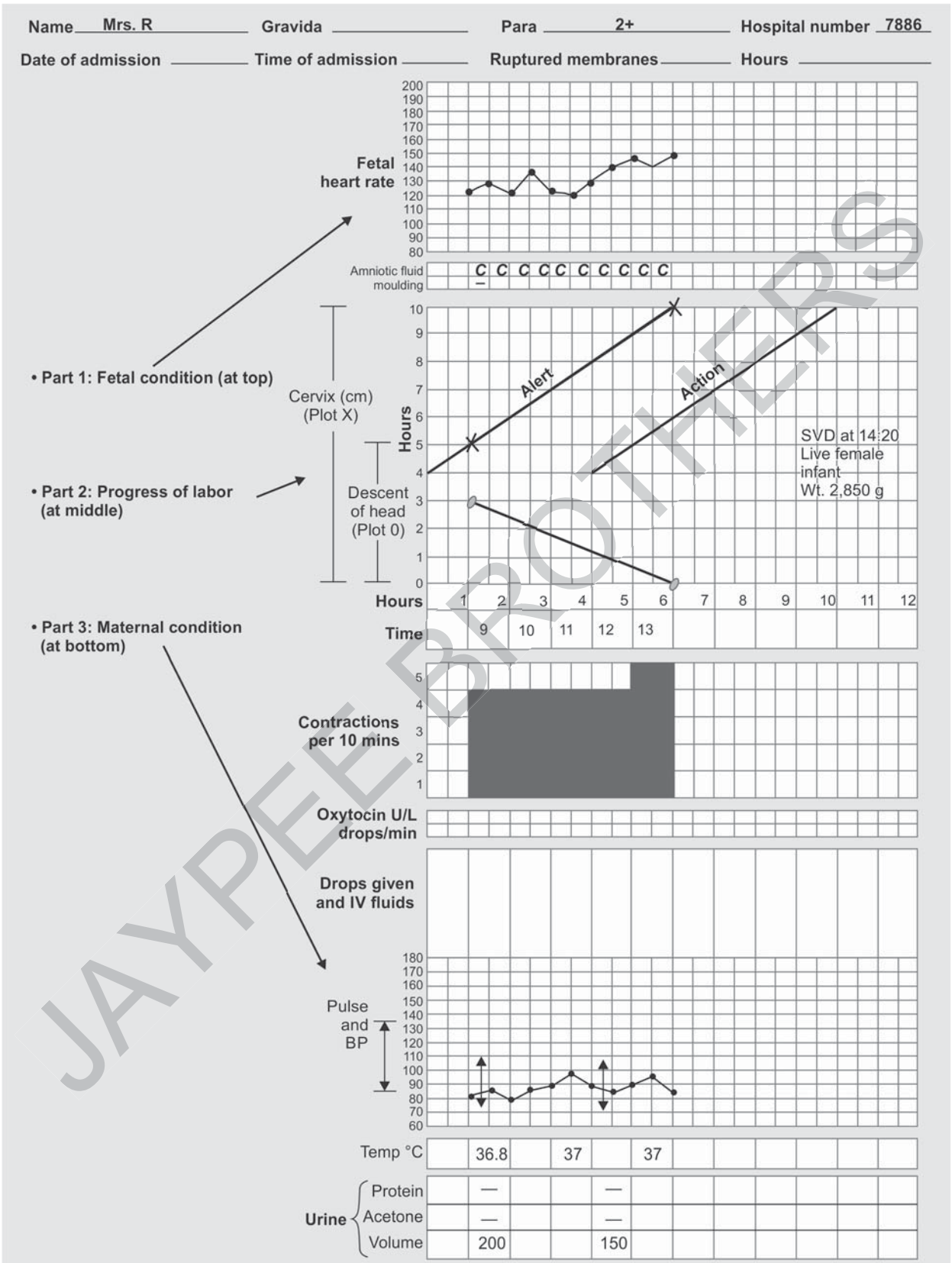


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**Fig. 5:** Components of partograph.

## Progress of Labor

The section of Partograph focuses on the central aspect of monitoring cervical dilation over time:

- **Active phase:** Once the cervix reaches 4 cm dilation, labor enters the active phase. In approximately 90% of primigravida, the cervix dilates at a rate of 1 cm per hour or faster during this phase.
- **Alert line:** The alert line, drawn from 4 cm to 10 cm, represents the expected rate of cervical dilation. If the dilation progresses to the right of this line, it indicates a slower-than-expected dilation, signaling a potential delay in labor. If the woman is in a healthcare center, she should be transferred to a hospital for necessary interventions and should be monitored more frequently.
- **Action line:** The action line is drawn 4 hours to the right of the alert line. If cervical dilation reaches this line, it calls for a critical assessment of the delay, and a decision should be made regarding the appropriate management to address the delay.
- **Cervical dilation:** The latent phase (slow period of cervical dilation) occurs from 0 to 4 cm, accompanied by a gradual shortening of the cervix. The active phase (rapid period of cervical dilation) spans from 4 cm to 10 cm, representing full cervical dilation. Cervical dilation is typically represented with an "X" on the graph.

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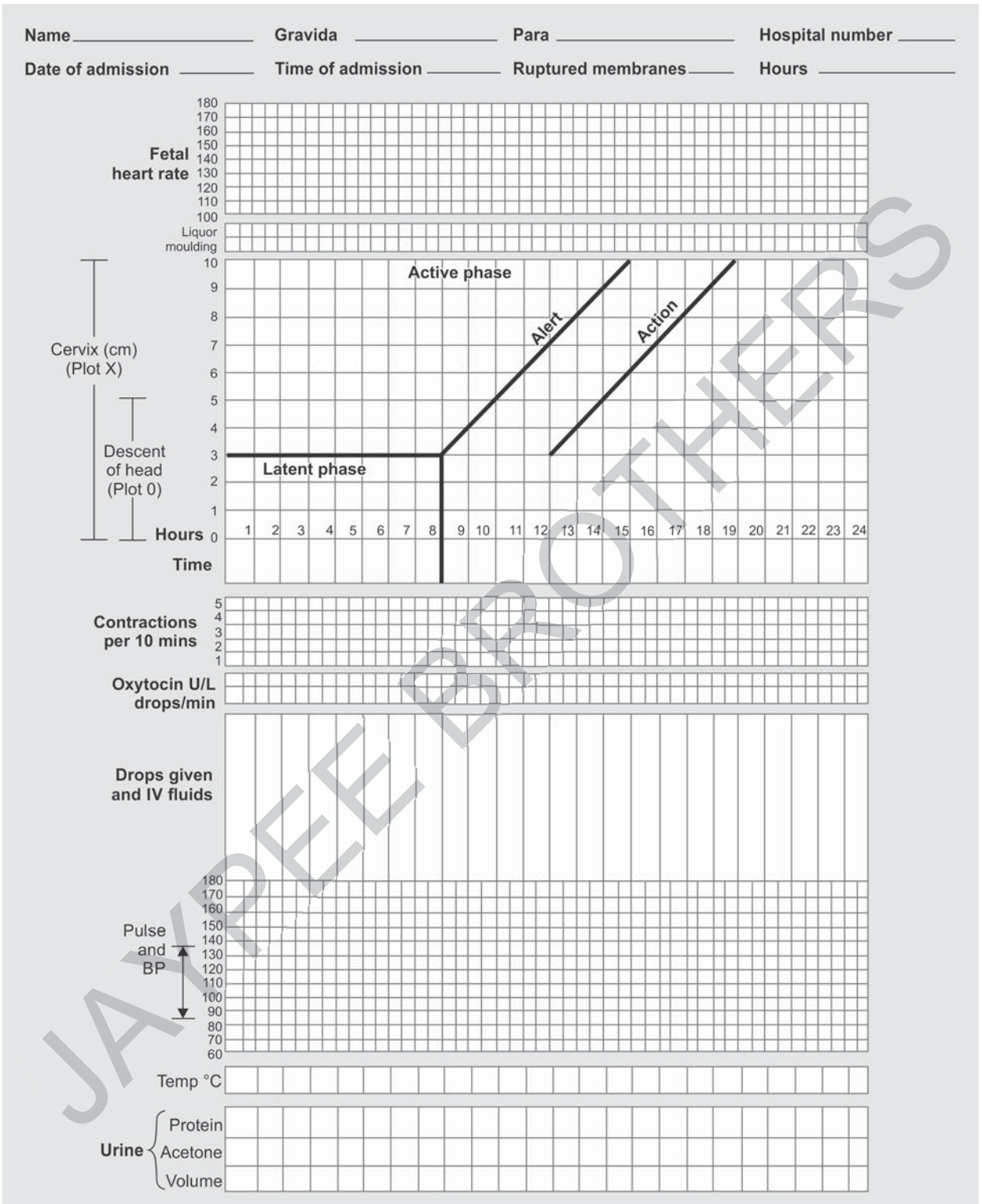


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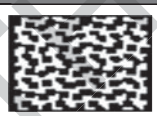
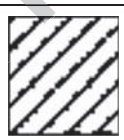
**Fig. 6:** Composite partograph (WHO).

## Points to Remember

- **Active phase rate:** The cervix should dilate at a rate of at least 1 cm per hour during the active phase.
- **Labor progress:** If labor is progressing well, cervical dilation should not move to the right of the alert line.
- **"0" hour:**
  - If the mother is admitted to the labor room during the active phase, "0" hour is the time of admission.
  - If the mother is already in the hospital, "0" hour is when cervical dilation reaches 3 cm, with at least two or more contractions in 10 minutes, each lasting more than 20 seconds.
- **Recording:** All observations must be recorded beneath the correct time entry on the partograph.

## Uterine Contractions

- **Frequency:** How often contractions are felt.
- **Duration:** How long each contraction lasts.

| *Duration* | *Grade* | *Shading pattern* |
|---|---|---|
| Less than 20 seconds | Mild |  |
| Between 21 and 40 seconds | Moderate |  |
| More than 40 seconds | Severe |  |

- Check the number of contractions in 10 minutes, record them, and shade the corresponding number of boxes accordingly.

## The Fetal Condition

- **Heart rate monitoring:**
  - The lines for 110 and 160 bpm are darker.
  - Check the fetal heart rate every 30 minutes and mark with a dot (•).
  - If an abnormal heart rate is detected, listen every 15 minutes for at least 1 minute immediately after contractions.
  - If the heart rate remains abnormal over three observations, action should be taken unless delivery is imminent.
  - A heartbeat of 100 bpm or lower indicates severe fetal distress, requiring immediate intervention.
- **Membranes and liquor:**
  - "I" for an intact membrane.
  - "C" for clear liquor.
  - "M" for meconium-stained liquor.
  - "B" for blood-stained liquor.
  - "A" for absent membrane.
  - If thick meconium or absent liquor is observed at any time after membrane rupture, monitor the fetal heart more frequently, as these could be signs of fetal distress.
  - If membranes have been ruptured for 12 hours or more, administer antibiotics prophylactically.

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- **Molding of the fetal skull bones:** Molding indicates how well the pelvis accommodates the fetal head. Increasing molding with the head high in the pelvis may indicate cephalopelvic disproportion.

*Recording Molding*

- If bones are separated and sutures can be easily felt: record as "O".
- If bones are just touching each other: record as "+".
- If bones are overlapping: record as "++".
- If bones are severely overlapping: record as "+++".

## The Maternal Condition

- **Pulse:** Record every 30 minutes and mark with a dot (•).
- **Blood pressure:** Record every 4 hours and mark with arrows.
- **Temperature:** Record every 2 hours.
- **Urine:** Check for the presence of protein and acetone, and measure the volume every time urine is passed.

# PER VAGINAL EXAMINATION

## Definition

Per Vaginal Examination (PVE) is an internal examination of the vagina and cervix conducted to evaluate the changes occurring during childbirth. By combining external and internal findings, a skilled midwife can gain a comprehensive understanding of labor progression.

## Indications

PVE is indicated in several scenarios, including:

- Diagnosing the onset of labor.
- Identifying the baby's presentation (position).
- Determining if the baby's head is engaged in the pelvis.
- Assessing the status of the membranes (whether they are intact or ruptured).
- Monitoring the progress or delay in labor.
- Applying fetal monitoring.
- Evaluating cervical dilation.
- Confirming the position and presentation of the second twin in multiple pregnancies.

## Purpose

The primary purposes of PVE include:

- Confirming the progress of labor.
- Monitoring cervical dilation and effacement.
- Checking the baby's presentation.
- Determining whether the forewaters have ruptured.
- Assessing the risk of cord prolapse.
- Evaluating labor progression or delays.
- Identifying the onset of the second stage of labor.
- Assessing the baby's head position and degree of molding.

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## Important Considerations

- PVE should be performed at least once every four hours during the first stage of labor, with findings recorded in the partograph.
- The examination must be conducted gently, thoroughly, and methodically, using aseptic techniques.
- Once the sterilized gloved fingers are removed after the examination, they should not be reintroduced under any circumstances.
- PVE should be avoided in cases of antepartum hemorrhage.

## Preparation of Environment

- Ensure the mother's privacy.
- Provide a comfortable bed or examination table.
- Ensure adequate lighting.
- Maintain a sterile field throughout the procedure.

## Preparation of the Mother

- **Physical preparation:**
  - Shave or trim the perineal area according to hospital policy during the first stage of labor.
  - Provide privacy and drape the woman appropriately for the examination.
  - Use extra pillows to raise the mother's head and place a mackintosh under her buttocks.
  - Ask the mother to flex her knees.
  - Perform the pelvic examination with the mother in the dorsal position, taking necessary aseptic precautions.
  - Position the mother in a lithotomy or dorsal position with thighs flexed and separated.
- **Psychological preparation:**
  - Clearly explain the procedure and its purpose to the mother to build trust and confidence.
  - Offer encouragement and reassurance to help her feel comfortable and supported during the examination.

## Articles Required

| *S.No.* | *Articles* | *Purpose* |
|---|---|---|
| 1. | Draping sheet | To ensure privacy |
| 2. | Mackintosh | To prevent bed soiling |
| 3. | Bowl with warm water | To cleanse the perineum |
| 4. | Antiseptic lotion (Betadine) | To sanitize the perineum |
| 5. | Cotton swabs, gauze, or gag pieces in a sterile container | For perineal cleaning |
| 6. | Long artery forceps | To hold swabs during cleaning |
| 7. | Sterile gloves | To maintain sterility and self-protection |
| 8. | Sterile pad | To cover the perineum if needed |
| 9. | Kidney tray and paper bag | To collect waste |
| 10. | Lubricating cream | For lubrication |

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## Steps of Procedure

| S.No. | Articles | Purpose |
|---|---|---|
| 1. | Identify the mother correctly by name, age, sex, and unique ID registration number. | To ensure the correct procedure is performed on the correct patient. |
| 2. | Explain the procedure to the mother. | To promote cooperation and compliance. |
| 3. | Advise the mother to empty her bladder if needed | To avoid discomfort during the procedure. |
| 4. | Review the chart for baseline findings, if available. | To serve as a reference for comparison. |
| 5. | Position the woman in the dorsal recumbent position with knees flexed. | For optimal visualization. |
| 6. | Drape the patient. | To maintain privacy. |
| 7. | Wash hands thoroughly and wear sterile gloves. | To prevent infection. |
| 8. | Observe the external genitalia for:<br>• Signs of varicosities, edema, vulval warts, or sores<br>• Scars from previous episiotomy<br>• Vaginal discharge or bleeding<br>• Color and odor of amniotic fluid, if membranes have ruptured. | To assess external genital health and identify any potential concerns. |
| 9. | Pour warm water or antiseptic lotion over the perineum using swabs. | To cleanse the perineal area of any discharge. |
| 10. | Clean the perineum with wet swabs. | To prevent bacterial infection. |
| 11. | Hold the swabs with forceps and clean from the top downwards. | To ensure proper perineal cleaning. |
| 12. | Use one swab per stroke. | To prevent cross-contamination. |
| 13. | Clean the perineum in the following order:<br>• Vulva<br>• Labia minora (farthest side)<br>• Labia minora (nearest side)<br>• Inner side of labia minora (farthest side)<br>• Inner side of labia minora (nearest side)<br>• Outer side of labia minora (farthest side)<br>• Outer side of labia minora (nearest side)<br>• Anus (in a circular motion) | To ensure thorough cleaning and prevent infection. |
| 14. | Separate the labia minora with the left hand and insert two lubricated fingers with lignocaine gel. As you explore the vagina, observe the following:<br>• State of the cervix (dilation and effacement)<br>• Presentation and position of the fetus<br>• Position and station of the presenting part, and membrane condition<br>• Station of the presenting part relative to the ischial spines<br>• Cephalopelvic disproportion in non-engaged head<br>• Elasticity of perineal muscles<br>• Character of any discharge<br>• Pelvic adequacy<br>• Molding of the fetal skull bones<br>• Do not remove fingers until the examination is complete. | To monitor labor progress and fetal position. |
| 15. | Clean the woman after the examination. | To ensure comfort. |
| 16. | Remove gloves and wash hands thoroughly. | To maintain hygiene and prevent infection. |

## Recording the Findings of Pelvic Examination

It is crucial to document the findings after each vaginal examination. These findings may vary between different women and even between different examinations of the same woman. The specific details to be recorded include:

- Condition of the external genitalia and vagina.
- Cervical consistency, effacement, and dilation.
- Status of the membranes—whether they are intact, leaking, or ruptured.
- If ruptured, note the color of the amniotic fluid.

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- Presentation and position of the fetus.
- Presence of caput and the station of the fetus.
- Prominence or lack of prominence of the ischial spines and ischial tuberosities.

## PLACENTAL EXAMINATION

### Definition

Placental examination involves a thorough inspection and assessment of the placenta and its membranes immediately after expulsion to ensure completeness and normalcy. At term, a healthy placenta typically exhibits the following characteristics:

- Diameter: 15 to 20 cm
- Shape: Discoid
- Thickness: 15 to 20 cm
- Cotyledons: 15 to 20 in number
- Cord length: Approximately 50 to 60 cm
- Umbilical cord: Contains 2 arteries and 1 vein
- Weight: Approximately 500 to 600 grams, which is about 1/6th of the baby's birth weight
- Membranes: Includes the amnion and chorion

### Objectives

- To ensure the complete expulsion of the placenta and membranes, with no retained parts.
- To examine the placenta for any abnormalities.
- To assess the umbilical cord for any irregularities.
- To observe the placenta for any unusual characteristics.

### Articles Required

| *S.No.* | *Articles* | *Rationale* |
|---|---|---|
| 1. | Placenta in a bowl | For examination |
| 2. | Mackintosh | To protect the table from soiling |
| 3. | Measuring tape | To measure the dimensions of the placenta |
| 4. | Weighing machine | To measure the weight of the placenta |
| 5. | Gloves | To protect hands |
| 6. | Plastic apron | To protect the examiner's clothing |
| 7. | Cotton swab | To separate the membranes |
| 8. | Kidney tray or paper bag | To collect waste |
| 9. | Yellow plastic bag | For the disposal of the placenta |

### Procedure

**Preparation of the articles:** Arrange all necessary items near the mother's bedside before beginning the procedure.

**Preparation of unit:**

- Ensure the examination area is well-ventilated and properly lit.
- Maintain a clean and orderly environment.

**Preparation of staff:**

- Wash your hands thoroughly.
- Wear gloves before performing the procedure.
- Don appropriate personal protective equipment (PPE).

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## Steps of Procedure

| *Procedure* | *Rationale* |
|---|---|
| Wash the placenta under running water | To remove blood clots and facilitate easy visualization. |
| **Examination of membrane** | |
| Hold the placenta by the cord, allowing the membrane to hang | For better visualization of the placenta. |
| Insert your hand into the opening and spread the membrane. | To assess the completeness of the placental membrane. |
| Place the placenta on a flat surface with the maternal side facing upwards | To assess the maternal surface, which should be dull red in color. |
| Count the total number of cotyledons, separated by sulci or fissures, noting any calcium deposits or infarcted areas. Report any missing cotyledons. | To identify any missing lobes and to assess the aging of the placenta. |
| Turn the placenta over so the fetal surface is facing upward. Note the site of umbilical cord insertion. | To check for any abnormalities. |
| Examine the fetal surface for color, appearance, cord insertion, and blood vessel distribution. | To detect any abnormalities. The fetal surface should be shiny, translucent, and grey in color. |
| Peel the amnion from the chorion up to the umbilical cord insertion site on the fetal surface. | To check for any abnormalities. |
| Check for any extra holes in the membrane. | To detect abnormalities. |
| **Examination of the placenta** | |
| Hold the placenta in both cupped hands. | To check for completeness of the placenta. |
| Place the placenta on a flat surface. | For easier visualization. |
| Measure the length using the extended palm, digits, and finger breadths. | To determine the length of the placenta. |
| Measure the diameter of the placenta. | To assess the shape of the placenta. |
| Measure the depth or thickness of the placenta. | To assess the thickness of the placenta. |
| Weigh the placenta. | To determine the weight of the placenta. |
| **Examination of the cord** | |
| Measure the length of the remaining cord attached to the placenta and the length of the cord with the baby to estimate the total cord length. | To check for any abnormalities. |
| Check for the presence of true and false knots. | To identify any abnormalities. |
| Examine the placenta for the number of arteries and veins. | To detect any congenital deformities. |

## Abnormalities of Placenta

- Large placenta
- Bipartite placenta
- Tripartite placenta
- Placenta succenturiate
- Placenta membranacea
- Placenta circumvallate
- Battledore placenta
- Velamentous placenta
- Single umbilical artery
- Long cord
- Short cord

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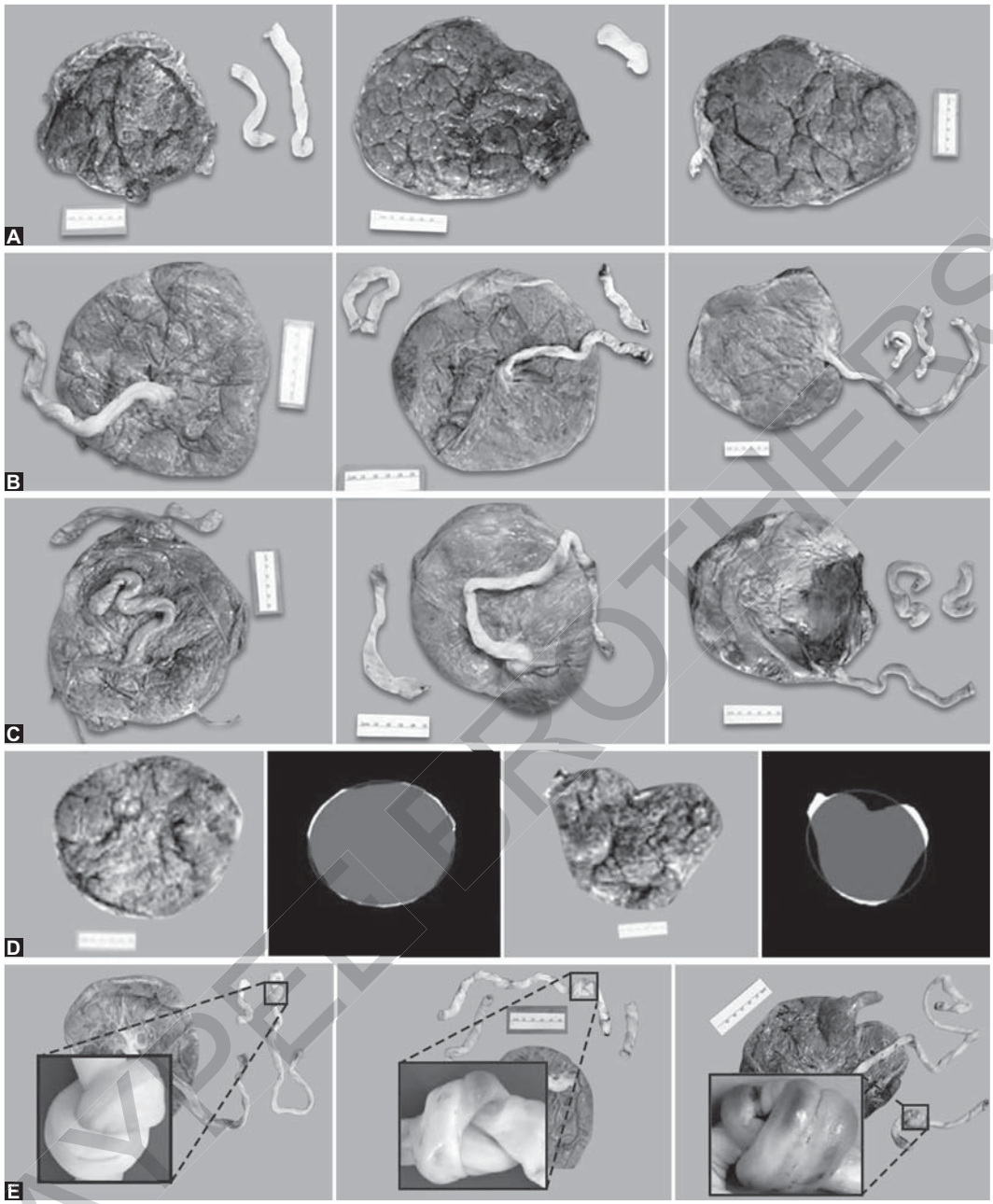


**Figs. 7A to E:** Abnormalities of placenta: A. Abruption; B. Chorioamnionitis; C. Meconium; D. Regular and irregular shapes; E. True knots.

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## Aftercare of the Articles and Mother

- Discard the placenta in the designated yellow bin.
- Wash your hands thoroughly with soap and water.
- Clean all the used articles properly and ensure they are completely dried.
- Dispose of all waste materials appropriately.
- Return all cleaned articles to their proper storage locations.

## Recording and Reporting

Document all observations made during the procedure, noting any abnormalities. Any abnormalities detected should be promptly recorded and reported to the appropriate higher authority for further action.

# PREPARING AND CONDUCTING NORMAL VAGINAL DELIVERY

## INTRODUCTION

The second stage of labor begins with the full dilation of the cervix and continues until the baby is delivered. Proper skills and training are essential to ensure a safe delivery, where both mother and baby remain healthy.

### Definition

Normal vaginal delivery involves evaluating uterine contractions during labor, which influence cervical dilation and expulsion of the fetus. The process includes the manual techniques used to assist the birth of the baby, the immediate care of the newborn, and the delivery of the placenta.

### Labor is Considered Normal when it Meets the Following Criteria

- It begins spontaneously at term.
- The baby presents in vertex (head-first) position.
- Labor progresses without undue delay.
- The process concludes naturally with minimal intervention.
- There are no complications that adversely affect the health of the mother or baby.

### Purposes

- To ensure the birthing process occurs in a well-prepared and safe environment.
- To conduct the delivery with minimal trauma to both mother and baby.
- To support the mother through labor, minimizing stress, injury, or complications.
- To facilitate a smooth and safe transition for the newborn from the intrauterine to the extrauterine environment.
- To prevent complications during labor and delivery.

### Articles for Mother

**A sterile delivery pack is required for the procedure, which includes the following items:**

| *S.No.* | *Articles* | *Purposes* |
|---|---|---|
| 1. | Sponge holding forceps: 1 | To hold a sponge for cleaning the perineum. |
| 2. | Artery forceps: 2 | To clamp the umbilical cord. |
| 3. | Cord cutting scissors | To cut the umbilical cord. |
| 4. | Cord clamp | To securely clamp the umbilical cord. |
| 5. | Small bowl containing Betadine | To apply over the wound after delivery for disinfection. |
| 6. | Gauze pieces | To clean the perineum. |
| 7. | Draping sheets and leggings | To drape the patient, ensuring privacy and a sterile field. |
| 8. | Cotton pads | To mop the area during the procedure. |
| 9. | Sanitary pads: 2 | To provide perineal support and apply over the perineum after delivery. |
| 10. | Basin | To collect the placenta after expulsion. |
| 11. | 4x4 gauze pieces | To wipe away secretions. |

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## Essential Items for Baby

| S.No. | Articles | Purposes |
|---|---|---|
| 1. | Baby blanket or flannel cloth (2) | For receiving and wrapping the baby. |
| 2. | Neonatal resuscitation equipment | To address any neonatal emergencies |
| 3. | Oxygen source with tubing | To provide oxygen support if necessary. |
| 4. | Suction apparatus and mucous extractor | For clearing secretions. |
| 5. | Cord clamp | To secure the umbilical cord after birth. |
| 6. | Bulb syringe | For gentle suctioning of the baby's nose and oropharynx. |



**Fig. 8:** Newborn baby corner.

## Medication Required

- Inj. Oxytocin 10 units: Administer intramuscularly.
- Inj. Methergin 0.2 mg/mL: Administer as needed (SOS).
- Tab. Misoprostol 200 mg: Administer four tablets as needed (SOS).

## Important Guidelines

- Ensure strict aseptic techniques are followed to prevent infection.
- Do not instruct the mother to bear down until full cervical dilation is achieved.
- Perform an episiotomy during the peak of a uterine contraction.
- Ensure all emergency equipment, such as resuscitation articles, oxygen, and suction pumps, are in proper working condition.
- Monitor and document any changes in uterine contractions or fetal heart rate (FHR).
- Record the timing of membrane rupture and note the color of the amniotic fluid.
- Measure the FHR between uterine contractions.

## Preparation for Labor

- Follow hospital policy for local preparation.
- Assess key factors such as fetal lie, presentation, position, attitude, cervical dilation, and effacement.
- If the membranes have ruptured, observe and document the color of the amniotic fluid.
- Maintain continuous fetal monitoring throughout labor.
- Avoid providing solid food to the mother, but encourage increased fluid intake.
- Instruct the mother to lie in the left lateral position during the first stage of labor.

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- Provide thorough guidance on breathing techniques for delivery.
- Offer comfort measures, such as back massages, to help relieve pain.
- Give psychological support and encouragement to the mother.
- Administer an enema as needed.

## Procedure Steps and Rationales

| S.No. | Steps | Rationale |
|---|---|---|
| 1. | Shift the mother to the delivery table as soon as the signs and symptoms of the second stage of labor appear. | To closely monitor the progress of labor. |
| 2. | Maintain a labor progress chart (partograph). | Helps in identifying any abnormalities during labor. |
| 3. | Position the mother in a dorsal position with legs flexed and abducted, or in a lithotomy position. | These positions enhance the natural process of delivery. |
| 4. | Open the delivery pack, arrange the necessary instruments, and pour cleansing solution into a bowl. | To ensure all materials are conveniently accessible for timely use. |
| 5. | Thoroughly wash hands, put on sterile gloves and gown. | To prevent cross-contamination and infection. |
| 6. | Clean the perineal area with a Betadine solution, following a specific cleaning order. | To thoroughly clean the perineal area and reduce infection risk. |
| 7. | Drain the bladder using a Foley catheter. | To relieve pressure on the uterus and facilitate delivery. |
| 8. | During contractions, instruct the mother to hold her thighs, take deep breaths, close her mouth, hold her breath, and push. Encourage her to take several deep breaths when the contraction subsides. | To assist the mother in effectively bearing down and to prevent exhaustion. |
| 9. | Provide sips of cold or warm water and wipe sweat from the mother's face with a wet sponge. | To maintain the mother's hydration and comfort. |
| 10. | During contractions, when the presenting part of the fetus is visible, drape the mother's abdomen and perineal area with a sterile towel. | To maintain the mother's privacy. |
| 11. | Support the perineum with your right palm using a perineal pad, and with your left hand, guide the occipital region of the head downward and backward. | To maintain head flexion and prevent perineal tears. |
| 12. | If indicated, perform an episiotomy under 1% xylocaine infiltration during crowning and at the peak of contraction. | To prevent severe perineal injury and facilitate a safe delivery. |
| 13. | Continue to provide perineal support with your left hand while maintaining head flexion with your right hand. | To minimize the risk of perineal injury. |
| 14. | Allow the head to be born gradually during contractions, ensuring the occiput passes under the symphysis pubis. | To control the extension of the head and prevent sudden movements that could cause injury. |
| 15. | Wait for the next contraction to deliver the shoulders. Check for any cord around the neck and, if present, determine if it's loose or tight. A loose cord can be slipped over the baby's head. | To prevent fetal distress and complications. |
| 16. | To deliver the shoulders, hold the fetus's head between both hands, lifting it toward the mother's abdomen. Deliver the posterior shoulder by applying downward traction and the anterior shoulder by upward traction. | To facilitate the delivery of the shoulders safely. |
| 17. | Administer 10 units of Oxytocin intramuscularly in the buttock. | To help control postpartum bleeding. |
| 18. | Deliver the rest of the trunk by applying lateral flexion. Instruct the mother to resist pushing and take deliberate breaths during this stage. | To facilitate a smooth delivery of the baby's body. |
| 19. | Record the time of birth. | To document the exact time of delivery. |

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| | | |
|---|---|---|
| 20. | Receive the baby in a clean, sterile towel, and place the baby on the mother's abdomen. If the baby is pink and crying, wait for the cord pulsations to stop before clamping. | To allow the baby to receive additional blood from the placenta and prevent cardiac overload. In cases of suspected asphyxia or Rh incompatibility, consider early cord clamping. |
| 21. | Wrap the baby in a clean, sterile towel. Assist with preparing identification cards for both the mother and baby. | To keep the baby warm and prevent hypothermia. |
| 22. | Suction the oral and nasal passages using a bulb syringe. | To prevent fluid aspiration in the newborn. |
| 23. | Monitor for signs of placental separation, such as lengthening of the cord, a gush of blood, and the fundus becoming round as the placenta descends into the vagina. | To assess the progress of placental separation. |
| 24. | Deliver the placenta using the Brandt-Andrews method by applying controlled cord traction and countertraction. | To carefully deliver the placenta and avoid complications. |
| 25. | When the placenta becomes visible at the vaginal introitus, ensure the fetal surface is outermost, and gently rotate the placenta as you support it with both hands. | To prevent complications during the third stage of labor. |
| 26. | Lift the baby towards the mother's abdomen to facilitate immediate contact. | To promote bonding and allow the mother to see her baby immediately. |
| 27. | Show the mother the baby's sex. | To confirm the baby's gender to the mother. |
| 28. | Examine the placenta and membranes for completeness and any abnormalities. Measure the cord length, estimate blood loss, and weigh the placenta. | To detect and address any potential complications early. |
| 29. | Inspect the vagina and perineum for any lacerations or tears. | To identify and manage any tears or lacerations. |
| 30. | Clean the perineum, apply sterile pads, dry the mother thoroughly, and position her laterally. | To ensure the mother's comfort and hygiene after delivery. |

## Aftercare of the Mother and Newborn

### *Mother's Care*

It is essential to monitor and record the following aspects to ensure the mother's well-being:

- **Vital signs:** Regularly check and document the blood pressure, pulse, and respiration to assess the mother's hemodynamic status.
- **Uterine consistency:** The uterus should be firm, resembling the hardness of a cricket ball, to confirm proper uterine tonicity.
- **Vaginal bleeding:** Assess vaginal bleeding immediately after delivery and then again after one hour before transferring the mother from the labor room to the ward.



**Fig. 9:** Postnatal mother.

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*Baby's Care*

- **Initial assessment:** Evaluate the newborn's condition, focusing on respiration, skin color, crying, limb movements, and checking for any congenital defects.
- **Newborn examination:** Conduct a comprehensive assessment and record the findings, including the baby's weight, length, and the circumference of the head, chest, and abdomen.
- **Breastfeeding initiation:** Place the baby with the mother and begin breastfeeding within the first 30 minutes of birth.
- **Immunization:** Administer the necessary vaccines at birth.
- **Vitamin K administration:** Provide 1 mg of vitamin K intramuscularly to prevent hemorrhagic disease in the newborn.

## POSTNATAL CARE

The postnatal period, spanning six to eight weeks after childbirth, is a critical time for both mother and baby. This phase marks the transition from antenatal care to postnatal care, emphasizing the need for the mother to rest, the initiation of breastfeeding, and care of any episiotomy or perineal wounds.

## POSTNATAL ASSESSMENT

### Definition

Postnatal examination refers to the systematic evaluation of both the mother and the newborn following childbirth. This examination also includes advice and guidance to be followed during the postnatal period.

### Aims and Objectives

- **Health assessment:** To evaluate the health status of the mother and baby, and provide necessary interventions.
- **Detection and treatment:** To identify and address any gynecological conditions or illnesses related to obstetric factors.
- **Baby's progress:** To monitor the baby's development and resolve any feeding issues.
- **Family planning guidance:** To offer advice on family planning options.

### Frequency of Examination

- **First examination:** Within 24 hours of delivery.
- **Second examination:** Before discharge.
- **Third examination:** Six weeks post-delivery.

### Examination of the Mother

**The mother's examination includes**

- Routine physical examination
- Obstetric examination
- Laboratory investigations
- Postnatal advice

### Assessment and Examination during the Postnatal Period

- Before the procedure
- History and preparation of the mother
- Collect the history as mentioned in following table

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| S.No. | Procedure | Rationale |
|---|---|---|
| 1. | Greet the mother. | It opens the channel for communication. |
| 2. | Collect information related to family profiles. For example:<br>• Support person<br>• Other children<br>• Type of housing<br>• Occupation<br>• Educational level<br>• Socioeconomic status | To collect identification data. |
| 3. | Pregnancy history<br>• Para<br>• Gravida<br>• Estimated due date (EDD)<br>• Any problems<br>• Hypertension or spotting | A quick review of pregnancy history is useful for further planning. |
| 4. | Delivery history<br>• Duration of labor<br>• Position of fetus<br>• Type of delivery<br>• Date and time of delivery<br>• Problems during labor | This information will help to plan postnatal procedures such as episiotomy care, etc. |
| 5. | Neonatal data<br>• Sex<br>• Birth weight<br>• Difficulty at birth<br>• Breastfeeding<br>• Any congenital anomalies | This information helps to plan care for the new-born |
| 6. | Postpartum data<br>• General health<br>• Activity level since delivery<br>• Description of lochia<br>• Any complain of pain in abdomen/breast/perineum | This information is helpful in assessment of the mother's present condition and planning of her care and health education imparted to her and the family. |

## Preparation of the Articles

### *Articles Required*

| S.No. | Articles | Purpose |
|---|---|---|
| 1. | Measuring tape | To measure the fundal height. |
| 2. | Weighing machine | To check the weight of the mother. |
| 3. | Vital signs articles | To assess the vital signs of the mother. |
| 4. | Cotton swabs | To clean the breast if any secretion is present. |
| 5. | Sterile perineal pad | To apply in the perineum. |
| 6. | Paper bag | To collect the soiled perineum. |

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The main components of postnatal assessment is denoted by the acronym **"BUBBLE-HE":**
**B—**Breast
**U—**Uterus
**B—**Bowel
**B—**Bladder
**L—**Lochia
**E—**Episiotomy
**H—**Homan's sign
**E—**Emotional status

## Steps

Wash hands and do full examination of the mother systematically as listed below:

a. **General appearance**
- *Degree of pallor:* To estimate blood loss.
- *Gesture of pain:* By her facial expression
- *Face:* Edema
- *Signs of venous thrombosis:* Homan's sign may elicit.

b. **Vital signs**
- *Pulse:* Rate, volume.
- *Respiration:* Rhythm and regularity.
- *BP:* To assess shock/PPH, persistent raised BP is indicative of postpartum toxemia.
- *Temperature:* Indicates infection

c. **Head-to-Toe examination**
- *Eyes:* Examine eyes for detecting anemia (conjunctiva)
- *Breast:*
  - Enquire about any discomfort and concern regarding breast and breastfeeding
  - Observe any abnormality of the nipple (i.e., cracked, retracted or depressed nipples)
  - Check for secretions from the breast.
  - Teach breastfeeding technique and care of breast to the mother while examining.
  - Palpate the breast to detect engorged breasts.
- *Uterus*
  - Ensure that the mother has emptied the bladder before examination
  - Ask the woman to lie on a flat surface.
  - Give a gentle fundal massage to stimulate uterine contraction to expel out the clots.
  - Take the fundal height from the fundus by placing the ulnar border of the left hand over the fundus and other on the symphysis pubis with a measuring tape. Note the findings in centimeters.
  - Note the consistency of the uterus.

  Findings: Uterus feels firm like a cricket ball and lies at or just below the umbilicus on day one. On subsequent days it descends down at the rate of 1 cm per day.
- *Perineum:* Ask the woman to turn on her side, inspect the perineum for:
  - Hematoma
  - Intact episiotomy stitches
  - Any discharge/bleeding from the wound
  - Swelling
  - Pain
  - Observe cleanliness
  - Observe any tendency of prolapse or stress incontinence.
  - Observe for episiotomy.

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- *Lochia*
  - Amount
  - Consistency
  - Color and
  - Odor
  - *Amount:* The amount of lochia is estimated by inspecting the drainage on the pads.
    Jacobson has standardized the assessment of lochia amount on the basis of saturation of pad which is as follows:
    - Stain of one inch or less—scant lochia
    - Stain up to less than 4 inches—light lochia
    - Stain up to less than 6 inches—moderate lochia
    - A fully saturated pad—heavy lochia
    - Saturation of pad within 15 minutes or saturation of more than one pad in 1 hour—hemorrhage
  - *Color*
    - Lochia rubra—red in color for 3–4 days
    - Lochia serosa—pinkish brown in color appears by 4th and lasts up to 10th day.
    - Lochia alba—whitish yellow in color appears by 10th day and lasts up to 16th day.




**Fig. 10:** Lochia.

  - *Consistency:* Clots in lochia may be present for the first 3 to 4 days and represent pooling of blood during periods even on inactivity of women. But are taken to be abnormal thereafter.
  - *Odor:* It may have a slight fishy odor but if there is foul or offensive smell it can be due to infection.
  - *Episiotomy:* Check episiotomy for **REEDA**
    **R—**Redness
    **E—**Edema
    **E—**Ecchymosis
    **D**—Discharge
    **A—**Approximation

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- **Observation for the signs of thrombophlebitis:** Check for Homan's sign in supine position, ask the lady to dorsiflex the leg, tell the mother to report if she experiences pain in her calf muscle.

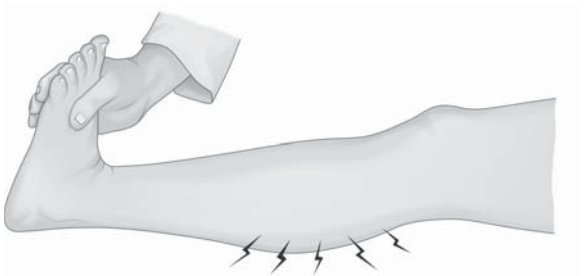

**Fig. 11:** Homan's sign

- **Assessment of bowel and bladder activities**
  Ask the woman:
  - Whether she has passed urine or not
  - About the amount and frequency of micturition
  - About pain and burning sensation during micturation
  - About incontinence
  - Ask whether she has passed her first motion after delivery
- **Assessing psychological changes**
  - Her facial expression
  - Involvement with the baby like breastfeeding, cuddling, talking to the baby and taking care of the baby.
  - Her appearance (grooming).

## Aftercare of the Mother and the Articles

1. Make the mother comfortable.
2. Collect all the soiled perineal pad and dispose of it in the dustbin by covering it with newspaper.
3. Put on a new sterile vulval pad.
4. Inform her about the findings of the examination.
5. Clean equipment and return to their places.
6. Wash your hands.

## Recording and Reporting

1. Record on patient's chart and nurse's note book with date and time.
2. Report any complication or abnormal findings to the consulting team.

# PERINEAL CARE/EPISIOTOMY CARE

## Definition

Perineal care is washing down of external genitalia and perineum under aseptic precautions.

## Purposes

1. To clean the perineal skin.
2. To stimulate the circulation and thus relieving the pain, inflammation and congestion.

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3. To promote healing by preventing infection.
4. To enhance comfort.

## Indications

1. Before per vaginal examination or any other per vaginal procedures.
2. Before or after delivery.
3. Postnatal mothers.
4. Post-abortion
5. Preoperatively and postoperatively (in the case of vaginal surgery)
6. Gynecological conditions—prolapsed uterus, any infection e.g., vaginitis.

## Articles

### *A Clean Tray Containing*

| *S.No.* | *Articles* | *Purpose* |
|---|---|---|
| 1. | Bowl containing betadine solution | To clean the perineum |
| 2. | Sterile gloves | To maintain sterility and self-protection |
| 3. | Mackintosh | To prevent the soiling of bed |
| 4. | Antiseptic or antibiotic medication | To clean the perineum |
| 5. | Sterile sanitary pad | To apply over the perineum |
| 6. | Draping sheet | To drape the patient |
| 7. | Measuring tape | To measure fundal height |
| 8. | Kidney tray | To discard waste |

### *Sterile Pack or Tray Containing*

| *S.No.* | *Articles* | *Purpose* |
|---|---|---|
| 1. | Artery forceps -1 | To hold the swabs for cleaning |
| 2. | Thumb forceps- 1 | To pick up the cotton swab from the bowl |
| 3. | Cotton balls | To clean the perineum |
| 4. | Gauze pieces | To dry the perineum |
| 5. | Cotton applicator | To apply ointment over episiotomy |

### *Additional Items*

| *S.No.* | *Articles* | *Purpose* |
|---|---|---|
| 1. | Infrared light | To give dry heat for healing of episiotomy |
| 2. | Bedpan | To collect the flushed water |
| 3. | Jug with warm water | To flush the perineum |
| 4. | Receptacle | For used perineal pad |
| 5. | Face mask | Needed in case of bad odor |

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## Procedure

| S.No. | Steps | Rationale |
|---|---|---|
| 1. | Identify the patient correctly. Collect the history of the patient. | To do the correct procedure on the correct patient. |
| 2. | Explain the procedure to the patient, the purpose and bladder and wash the perineal area before coming for perineal care. | To obtain co-operation. |
| 3. | Assemble all the articles bedside. | Saves time and energy. |
| 4. | Instruct the patient to empty her bowel and bladder and wash the perineal area. | A full bladder may cause upward displacement of the uterus. |
| 5. | Screen the patient. | To provide privacy. |
| 6. | Spread mackintosh (with lining) and keep kidney tray and paper bag nearby | To prevent soiling of linen. |
| 7. | Make the patient in dorsal recumbent position with knees bent and drape the area using diamond draping method. | Helps in better viewing of the perineum. |
| 8. | Open the sterile tray, arrange the articles. Pour betadine solution into the bowl. Keep the swabs required for perineal care in the bowl. | To prepare for the procedure. |
| 9. | Wear gloves | To prevent contact with body secretions. |
| 10. | Fold the lower corner of the bath blanket up between the client's legs onto the abdomen. | Keeping the mother draped which helps to minimize anxiety. |
| 11. | Untie the pad and observe lochia using clean forceps. | To detect evidence of infection and PPH if any. |
| 12. | Discard the pad in the bucket lined with a yellow bag. | Pads soiled with body fluids must be discarded in a yellow bin as per bio-hazard control guidelines. |
| 13. | Massage the uterus and the patient passes urine if she wishes too. | As it helps in expulsion of clots. |
| 14. | Place the bed pan under the patient and pour lukewarm water on the vulva. | Protect bed linen from soiling. |
| 15. | Wash your hands again thoroughly. | Reduced spread of infection. |
| 16. | Apply sterile gloves | To prevent contact with body fluids and prevent spread of infection. |
| 17. | Take the cotton swabs with artery forceps, dip in betadine solution and squeeze the excess solution with dissecting forceps into the kidney tray. | To maintain asepsis. |
| 18. | Gently retract the labia with a non-dominant hand. Using sterile swabs, wash carefully in skin folds with a dominant hand. Clean the vestibule from clitoris to fourchette in a single downward stroke. | Cleaning from a cleaner area to a less clean area prevents contamination. |
| 19. | Now, clean the perineum from the midline outward in the following order:<br>• Labia minora-farthest side<br>• Labia minora-nearest side<br>• Inner side labia majora-farthest side<br>• Inner side labia majora-nearest side<br>• Outer side labia majora-farthest side<br>• Outer side labia majora-nearest side<br>Clean the anus thoroughly in a circular motion | To clean the perineum. |
| 20. | Check the episiotomy for REEDA (redness, ecchymosis, edema, discharge and approximation of stiches) and clean the episiotomy with a single stroke in a rolling manner with a cotton applicator. | To assess the episiotomy. |

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| | | |
|---|---|---|
| 21. | Apply ointment (soframycin or betadine) over the episiotomy. | To prevent infection in the episiotomy wound. |
| 22. | Apply the pad over the perineum | To prevent soiling of clothes and linen. |
| 23. | Remove the bed pan. | Reduces transmission of infection. |
| 24. | Secure the pad with a T-binder | To secure the pad. |
| 25. | Turn the mother to the left side and clean the buttock in upward direction. | Side-lying position is a more comfortable position. |

## Special Consideration

- Use of infra-red light can be done for healing of episiotomy.
- If a sitz bath is prescribed, give it before perineal care.



**Fig. 12:** Sitz bath.

## After Care of the Mother and Article

- Make the mother comfortable.
- Remove the bed pan and mackintosh and replace all the articles after washing for sterilizing.
- Inform the mother about the nature of lochia and condition of the perineal wound.
- Tidy the unit.

## Recording and Reporting

- Record the procedure and any abnormal findings (discharge and condition of genitalia)
- Record—type of lochia, condition of stitches, fundal height.

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