

**Skills Checklist - Antenatal
Assessment and Treatment**

	Date	Date	Date	Date
A. Fundal Height Growth Monitoring				
1. Ask if the baby is active and moving normally.				
2. Palpate the woman's abdomen and check the fetal growth at each antenatal visit.				
3. If the uterus measures more than two centimeters different than expected, look for:				
• Wrong dates.				
• Abnormalities of the baby.				
• Too much amniotic fluid (liquor).				
• Twins or triplets.				
• A large baby.				
• Abnormal presentation of the baby (breech).				
4. Gestation under 20 weeks: estimate gestational age (age of the pregnancy), using your usual method.				
5. Gestation 20 weeks or more: use your usual method.				
• For measuring tape:				
- cm = weeks of pregnancy (gestational age).				
- if growth is 2 cm less or more than the weeks of pregnancy, try to figure out why.				
• Compare fundal height to umbilicus and sternum:				
- halfway (4 fingers above umbilicus) = 28 weeks.				

	Date	Date	Date	Date
- at sternum = 36 weeks' gestation.				
- if growth is less or more for the weeks of pregnancy, try to figure out why.				
6. Refer her to a doctor/hospital if a problem is found:				
• Baby does not feel normal.				
• Too much amniotic fluid (liquor).				
• Twins.				
• Very large baby.				
• Baby not cephalic presentation.				
• Fundal height not the same as gestational age.				
• Baby not growing.				
• Other problems.				
7. Record all information.				
• If you can not find an explanation for your finding, have her return in one week and remeasure.				
B. Checking for Anemia				
1. At the first antenatal visit ASK and LISTEN what the woman eats.				
• Get a complete diet history, how many servings a day?				
• ASK if she eats non-foods (pica)?				
• ASK if she has: fatigue, drowsiness, headaches, sore tongue, loss of appetite, nausea, or vomiting?				

	Date	Date	Date	Date
2. Check the woman's history. Find out if this woman is at high risk to develop anemia.				
• Have her pregnancies been closely spaced?				
• Does she have a history of heavy or long periods?				
• Does she have a history of anemia?				
• Does she bruise easily?				
• Has she had hemorrhage with any pregnancy or surgery?				
3. At each visit, LOOK at the woman's:				
• Eyelids.				
• Nail beds.				
• Gums.				
• Palms.				
4. Check her hemoglobin at her first visit. Repeat her hemoglobin every visit if 8 gm or below. Check her hemoglobin every two months if above 8 gm.				
5. If these problems occur in your area:				
• Do a sickle cell screen.				
• Check her blood for malaria.				
• Check her stool.				
6. Find out what treatments and medications she is taking. Give advice if any of the treatments or medications are harmful.				
7. Counsel the woman on:				

	Date	Date	Date	Date
<ul style="list-style-type: none"> High iron foods. 				
<ul style="list-style-type: none"> High folic acid foods. 				
<ul style="list-style-type: none"> High Vitamin C foods. 				
<ul style="list-style-type: none"> Good protein food sources. 				
8. Give ferrous sulfate 320 mg (60 mg elemental iron) two times a day. Increase her iron to three times a day for a hemoglobin 8 grams or lower.				
<ul style="list-style-type: none"> If hemoglobin has not improved with treatment, repeat her stool specimen looking for hookworm and other parasites. 				
<ul style="list-style-type: none"> At each visit, ASK if has enough medicines. 				
<ul style="list-style-type: none"> ASK how she is taking them to be sure she is taking them correctly and regularly. 				
9. Give folic acid 500 mcg each day to prevent anemia.				
10. Give Vitamin C 250 mg daily or advise 3 daily servings of citrus or leafy green vegetables.				
11. Give malaria prophylaxis according to the routine in your area.				
12. If her stool is positive for parasites, treat for the parasite identified.				
13. If the woman is more than 28 weeks' gestation at registration (booking) with a hemoglobin of less than 8 gm (55%):				
<ul style="list-style-type: none"> Refer her to a doctor for a complete anemia workup and treatment. 				
14. Give nutrition advice to girls and women who are not pregnant to prepare their bodies for the increased demands of pregnancy.				

	Date	Date	Date	Date
C. Checking for Pregnancy Induced Hypertension (Pre-eclampsia)				
1. Take a good symptom history. ASK if she has had:				
• Epigastric pain (heart burn) not related to malaria.				
• Headaches.				
• Visual problems (double vision, partial vision, rings around lights).				
• Edema or swelling of the hands, face, and feet.				
2. Take the blood pressure at every visit.				
• If elevated, check again in 20 minutes.				
3. If the blood pressure is elevated:				
• Check the biceps and patellar reflexes.				
• If the reflexes are brisk (plus 3 or plus 4), refer her to a hospital/doctor.				
4. If the blood pressure is elevated:				
• Check a midstream urine sample for protein.				
• If she has +1 or more proteinuria (albuminuria), refer her to a hospital/doctor.				
5. Do not give diuretics.				
6. In the case of severe pre-eclampsia:				
• Give magnesium sulfate 10 grams OR				
• Give Valium 10 - 20 mg.				
• Go with her to the hospital/doctor.				
7. If the woman has eclampsia (convulsions):				

	Date	Date	Date	Date
<ul style="list-style-type: none"> Protect her from choking on her tongue with a padded tongue blade or a rolled pad of cloth. 				
<ul style="list-style-type: none"> Do not force the mouth open. 				
<ul style="list-style-type: none"> Protect her from falling or injury from nearby furniture or objects. 				
<ul style="list-style-type: none"> Give magnesium sulfate 10 gm OR Valium 10 - 20 mg. 				
<ul style="list-style-type: none"> Transfer her right away to the nearest hospital/doctor. 				
<ul style="list-style-type: none"> Travel with the woman, avoiding stimulation. 				
<ul style="list-style-type: none"> Record all complaints, findings, and care. Take her antenatal card with you. 				
<ul style="list-style-type: none"> Give medical personnel a complete summary of care given. 				
<ul style="list-style-type: none"> Give the woman's records to the hospital personnel. 				

Comments:

**Skills Checklist - Monitoring
Labor Progress on
Admission**

	Date	Date	Date	Date
When monitoring the progress of a woman in labor on admission:				
1. Collect all equipment, wash your hands.				
2. Welcome and prepare the mother:				
• Explain what you are going to do.				
• Ask her to sit or lie in a comfortable position.				
• Decide whether the woman is about to deliver; she may be fully dilated.				
3. ASK and LISTEN, RECORD:				
• Patient information, including time of arrival.				
• When contractions began, how often contractions occur?				
• Whether the woman has gone to antenatal clinic?				
• Whether bag of water has broken, any bloody show?				
• When the woman last ate?				
• When she last passed stool?				
• Whether she had any medications to increase or decrease the labor and whether they worked?				
• Name of TBA, whether TBA knows woman is in labor, where TBA can be reached?				

	Date	Date	Date	Date
4. LOOK and FEEL, RECORD. Help the woman get ready for examination; explain what you are going to do.				
5. ASK the woman to pass urine so her bladder will be empty.				
6. LOOK at her general condition and do a general examination including:				
• Vital signs and height.				
• General appearance: nutrition, illness, tired.				

<ul style="list-style-type: none"> • Checking eyes, ears, nose, mouth, throat. 				
<ul style="list-style-type: none"> • Checking neck for enlarged veins. 				
<ul style="list-style-type: none"> • Breathing: how fast, breathing sounds. 				
<ul style="list-style-type: none"> • Heart: how fast, regular. 				
<ul style="list-style-type: none"> • Breasts. 				
<ul style="list-style-type: none"> • Arms, legs, back: swelling, veins, deformities. 				
7. Tell the woman that you are now going to do an abdominal examination. Explain to her that you need to feel the baby and find out how the baby is lying in her abdomen.				
8. Stand at the woman's side, look at the abdomen and the way the baby is lying.				
9. Feel the woman's abdomen.				
<ul style="list-style-type: none"> • Decide the strength and length of contractions. 				

	Date	Date	Date	Date
• Count how many contractions in 10 minutes.				
• Start at top of abdomen: - Feel shape, size, firmness, mobility. - Decide what part of baby is at top of uterus.				
• Put your hands on lower abdomen, feel for arms, legs, back, head of baby.				
• Ask woman to bend her knees:				
- Hold the part of baby in lowest part of abdomen.				
- Decide what part of the baby you feel.				
10. Listen to the heart beat over the chest or back of the baby. Count the heart rate.				
11. Record your abdominal examination findings on the partograph. Explain your findings to the mother.				
12. See vaginal examination , page 3.74.				

Comments:

**Skills Checklist - Monitoring
Labor Progress**

	Date	Date	Date	Date
When monitoring the progress of a woman in labor :				
ASK and LISTEN - General well being.				
LOOK and FEEL				
1. Abdominal examination				
Descent of baby: <ul style="list-style-type: none"> • Latent phase - every 4 hours. • Active phase - every 2 hours. 				
Contractions for 10 minutes: <ul style="list-style-type: none"> • Latent phase - every 1 hour. • Active phase - every 30 minutes. 				
Fetal heart beat , at least every hour: <ul style="list-style-type: none"> • Latent phase - every 1 hour. • Active phase - every 30 minutes. 				
2. Vaginal exam every 4 hours or as needed:				
• Explain what you are going to do.				
• Gather equipment; wash hands.				
• Ask woman to lie on her back with her legs apart and knees bent.				
• Explain each step of exam before you do it.				
• Wash hands, put on gloves.				
• LOOK for discharge.				
• Wash genital area and vulva with soap/water or antiseptic solution.				
• Moisten fingers of gloved examining hand.				
• Insert fingers into vagina.				

	Date	Date	Date	Date
• FEEL vaginal wall temperature/moisture.				
• FEEL for hard scarring/stool.				
• FEEL cervix:				
- Thickness (effacement).				
- Tight or stretchy.				
- Dilatation.				
• FEEL bag of waters:				
- Broken.				
- Bulging.				

- Prolapsed cord.				
• LOOK at color of amniotic fluid (liquor).				
• FEEL presenting part, descent, and position:				
- Caput.				
- Molding.				
- If indicated at first exam, assess pelvic size, see page 3.69.				
• Remove hand from vagina.				
• Help woman get comfortable.				
• Explain findings to woman and family.				
IDENTIFY PROBLEMS/ NEEDS; TAKE ACTION				
3. Vital signs every 4 hours:				
• Hydrate at least every hour.				

	Date	Date	Date	Date
• Have woman urinate at least 2 - 4 hours.				
• Care for mother:				
- Change position often.				
- Encourage activity.				
- Rub her back.				
- Reassure/encourage/help.				
- Explain progress to mother/family.				
• Record findings and actions.				
• Interpret partograph:				
- Latent stage				
- Active stage				
- Alert line				
- Action line				
• REFER as necessary.				

Comments:

**Skills Checklist for
Episiotomy and Laceration
Repair**

Date Date Date Date

A. Procedure for Giving Local Anesthesia	Date	Date	Date	Date
Put a 22 gauge, 1 ½ inch needle on a syringe.				
1. Fill the syringe with local anesthetic.				
2. Place your two fingers between the baby's head and the perineum, if giving anesthetic before delivery.				
3. Insert the whole length of the needle from the fourchette, running just below the skin, down the direction of episiotomy.				
<ul style="list-style-type: none"> • Pull back on the plunger of the syringe to check for blood. 				
<ul style="list-style-type: none"> • Inject evenly as you withdraw the needle. 				
4. Now angle the needle to one side of center.				
<ul style="list-style-type: none"> • Repeat the steps in 3. 				
<ul style="list-style-type: none"> • Repeat on the other side. 				
<ul style="list-style-type: none"> • Repeat going up the center of the vagina. 				
5. About 10 cc of anesthetic has been injected.				
6. Wait a minute or two for the anesthesia to take effect.				
7. During the repair, if the woman is uncomfortable, inject up to 10 cc more of 1% local anesthetic in the area where the woman feels pain.				
B. Procedure for Cutting an Episiotomy				
1. LOOK and FEEL.				

	Date	Date	Date	Date
<ul style="list-style-type: none"> Is the perineum long or short? 				
<ul style="list-style-type: none"> Thick or thin? 				
<ul style="list-style-type: none"> Does it have varicose veins, genital warts, or other problems. 				
2. If you are not close to a hospital/doctor, do a mediolateral episiotomy.				
3. Cut an episiotomy when the perineum is thinned and pale or shiny.				
4. Take a pair of scissors with one rounded blade or bandage scissors (good condition).				
<ul style="list-style-type: none"> Place 2 fingers of your other hand in the vagina between the scissors and baby's head. 				
<ul style="list-style-type: none"> Start at the center of the perineum and angle (slant) your scissors out at a 45 degree angle. 				
<ul style="list-style-type: none"> If you are right handed, cut towards the mother's right buttock. 				
5. Make the episiotomy with one or 2 large cuts.				
6. After the perineal cut has been made, turn your scissors around, positioned up the vagina.				
<ul style="list-style-type: none"> With your other hand, protect the baby's head with your fingers. 				
<ul style="list-style-type: none"> Cut up the center of the vagina 5 to 7.5 cm (2 to 3 inches). (This cut allows more space in the vagina and helps to prevent tearing up from the perineal cut.) 				
7. Press a gauze firmly over the cut area while the woman continues to push with contractions.				

	Date	Date	Date	Date
8. Use sterile technique.				
C. Procedure for Cervical and Vaginal Inspection				
1. Explain to the woman what you are going to do.				
2. Quickly and gently wash off the woman's genitals.				
<ul style="list-style-type: none"> With your gloved hand, separate the labia (vaginal lips). 				
<ul style="list-style-type: none"> Have your assistant shine a light into her vagina. 				
3. Look carefully for any tears or hematomas (collection of blood under the tissue).				
<ul style="list-style-type: none"> Press firmly on the back wall of the vagina with your fingers. 				
<ul style="list-style-type: none"> Look deep into the vagina. 				
4. Slowly pressing against the vaginal wall, move your fingers up the side wall of the vagina, one side at a time.				
LOOK and FEEL:				
<ul style="list-style-type: none"> Is the surface smooth? 				
<ul style="list-style-type: none"> Are there any points where you notice bleeding? 				
<ul style="list-style-type: none"> Did you feel all the way up the vagina to the cervix? 				
5. Have your assistant press firmly down on the woman's uterus.				
<ul style="list-style-type: none"> Press firmly on the back wall of the vagina with one hand. Look for bleeding or tears. 				

	Date	Date	Date	Date
<ul style="list-style-type: none"> If you see bleeding or tears, take the sponge forceps (ring forceps) and clamp them on the anterior lip (top lip) of the cervix. 				
<ul style="list-style-type: none"> Clamp the entire rounded part of forceps onto the tissue. 				
<ul style="list-style-type: none"> Pull gently on the forceps. 				
<ul style="list-style-type: none"> LOOK at the cervix. 				
<ul style="list-style-type: none"> LOOK at all sides of the cervix carefully. 				
<ul style="list-style-type: none"> Take a sterile gauze or cloth and wipe the blood away. 				
<ul style="list-style-type: none"> LOOK and find: is the bleeding coming from the uterus, vaginal laceration, or cervical laceration? 				
6. If the bleeding is from the uterus, give an oxytocic medication and massage the uterus.				
<ul style="list-style-type: none"> If the bleeding is from a laceration, repair it. 				
<ul style="list-style-type: none"> If no lacerations or bleeding are noted, remove the sponge forceps; make the woman comfortable; continue to monitor her vital signs for 2 hours. 				
7. If the lacerations seen are very large or deep, or if the patient does not improve with intravenous rehydration, pack her vagina with a tampon of sterile gauze or cloth and prepare to transport her immediately.				
D. Preparation for Episiotomy or Laceration Repair				
1. Get equipment ready.				

	Date	Date	Date	Date
2. Position the woman's buttocks at the edge of the bed or table. Her legs may be supported by stirrups or held by family members.				
3. Remove any soiled cloths from under her and wash her genitals.				
4. Put on fresh gloves or wash gloved hands with soap and water.				
5. Place a sterile or very clean towel or cloth under the buttocks.				
6. Check to see if the local anesthetic is working well.				
<ul style="list-style-type: none"> • Touch the cut areas with the sharp point of a needle. 				
<ul style="list-style-type: none"> • If she feels sharp pain, give her some more anesthesia before the repair. 				
7. If there is no time to give anesthetic before delivery or if it is a laceration you are repairing, give the local anesthesia now.				
8. Have your light source adjusted so you can see well into the vagina.				
9. Sit down and make yourself comfortable.				
10. Perform a complete vaginal, cervical, and perineal inspection.				
11. Open the suture and gently stretch it out straight.				
12. Place the needle in the needle holder at the right angle.				
<ul style="list-style-type: none"> • Clamp the teeth of the holder firmly shut. 				

	Date	Date	Date	Date
E. Procedure for Episiotomy Repair				
1. Run your finger through the whole wound (cut).				
<ul style="list-style-type: none"> See clearly where the top of the wound is. 				
<ul style="list-style-type: none"> Place your first suture about 1 cm ($\frac{1}{2}$ inch) above the top of the wound in the vagina. Pull it through with your thumb forceps. 				
<ul style="list-style-type: none"> Tie it off with a square knot, and trim off the short thread to about 1 cm ($\frac{1}{2}$ inch). 				
2. Suture the vaginal mucosa using a continuous stitch (continuous suturing), sewing down to the hymenal ring.				
3. Put the needle through vaginal mucosa behind the hymenal ring, and bring it out on the wound of the perineum.				
4. Continue using the suture sparing continuous method to suture all the way to the bottom of the wound.				
5. Once you have reached the very end of the wound, turn the needle over and start to sew again using continuous stitches to close the subcuticular tissue.				
<ul style="list-style-type: none"> Always use your forceps to pull the needle through. 				
<ul style="list-style-type: none"> This second layer of suture will leave the wound about 0.5 cm ($\frac{1}{4}$ inch) open. This will close well by itself as healing occurs. 				
6. Move the suture again from the perineal part of the wound back into the vagina and secure it.				
7. Tie off the suture with a square knot.				

	Date	Date	Date	Date
<ul style="list-style-type: none"> Cut the 2 ends of suture leaving about 1 cm (½ inch). 				
8. Double check to make certain that you have not left any gauze, tampon, or instruments in the woman's vagina.				
<ul style="list-style-type: none"> Perform a rectal exam to check that no stitch is in the rectum if this is a midline (medial) episiotomy. 				
<ul style="list-style-type: none"> Wash the genitals with soap and water. 				
<ul style="list-style-type: none"> Make mother dry and comfortable. 				
F. Procedure for Repair of Lacerations				
1. If the laceration is periurethral (around the urethra), place a catheter in the bladder. This helps you identify the urethra and keeps you from accidentally sewing the urethra shut or damaging it.				
2. Choose the finest (most narrow) suture you have (see the section on how to choose a suture in Learning Aid 1, page 4.26).				
3. Press the tissue together.				
<ul style="list-style-type: none"> Put the ragged pieces together again so that the tissue looks like before. Do not hurry this part. 				
4. Place interrupted sutures the length of the shallow tear about 1 cm apart. Make an interrupted stitch:				
<ul style="list-style-type: none"> Take a bite of tissue. 				
<ul style="list-style-type: none"> Bring it through to the center of the tear. 				
<ul style="list-style-type: none"> Look for the needle. 				
<ul style="list-style-type: none"> Check that it is not too deep or too shallow. 				

	Date	Date	Date	Date
<ul style="list-style-type: none"> • Push it through the other side of the tear with the same size bite of tissue. 				
<ul style="list-style-type: none"> • Pull the suture through leaving just enough of an end (5 to 8 cm) so that you can tie the suture with a square knot. 				
5. Continue making interrupted (individual) sutures for the full length of the laceration. Remember: the most important thing is to control the bleeding.				
<ul style="list-style-type: none"> • If she continues to ooze blood from the laceration, press a gauze firmly over the wound for 10 minutes, do not look. 				
<ul style="list-style-type: none"> • After 10 minutes, carefully take off the gauze. 				
<ul style="list-style-type: none"> • If the tear has stopped bleeding, the sutures are enough. 				
<ul style="list-style-type: none"> • If she continues to ooze or bleed actively, you will need to add one or more stitches to control the bleeding. 				
G. Procedure for Repair of Lacerations of the Cervix:				
<ul style="list-style-type: none"> • Place your sponge forceps on one side of the laceration. 				
<ul style="list-style-type: none"> • If you have a second sponge forceps, place it on the other side of the laceration. 				
<ul style="list-style-type: none"> • Place the handles from both forceps in one hand. 				
<ul style="list-style-type: none"> • Gently bring handles toward you. 				
<ul style="list-style-type: none"> • Place interrupted sutures the length of the wound about 1 cm apart. 				

	Date	Date	Date	Date
<ul style="list-style-type: none"> If you do not have sponge forceps to grasp the cervix, have your assistant put on a pair of gloves. 				
<ul style="list-style-type: none"> Have her press on the posterior (back) wall of the vagina. This will help hold it out of the way so that you can see the laceration better. 				
H. Record Findings				
<ul style="list-style-type: none"> Record progress of vital signs throughout procedure. 				
<ul style="list-style-type: none"> Record type and amount of IV fluids and time started. 				
<ul style="list-style-type: none"> Record estimated blood loss. 				
<ul style="list-style-type: none"> Record location and appearance of laceration or episiotomy (you may wish to make a drawing of the location). 				
<ul style="list-style-type: none"> Record time, type and dose of medications or treatment given. 				

Comments:

**Skills Checklist - Active
Management of Third Stage**

	Date	Date	Date	Date
When you actively manage the third stage:				
Prepare oxytocic in syringe before second stage; ensure empty bladder; place mother in a semi-sitting or a squatting position.				
1. Ask assistant to give oxytocic with delivery of anterior shoulder or give as soon as possible.				
2. Dry and cover baby. Clamp and cut cord.				
3. Ask assistant if available to put baby to breast.				
4. The side of one hand is placed against the lower half of the uterus just above the symphysis pubis.				
5. The other hand pulls with firm, steady tension on the cord with uterine contraction.				
6. Deliver placenta: slowly, support with both hands; deliver membranes gently with a turning motion.				
7. Rub uterus until hard.				
8. Expel blood and clots.				
9. LOOK at placenta and membranes to see that they are complete.				
10. Record information.				

	Date	Date	Date	Date
11. Store oxytocic in a cool place out of the sun to preserve the potency of the medication.				

Comments:

**Skills Checklist - Infant
Resuscitation**

	Date	Date	Date	Date
When caring for a baby at birth:				
1. Have equipment ready for infant resuscitation.				
2. Find an assistant to help you.				
3. DRY: As soon as the head is delivered, wipe fluids from baby's mouth and nose using fingers or cloth .				
• Dry with cloth from head to toe.				
4. WARM: Remove the first wet cloth.				
• Cover with another dry cloth or place baby skin to skin with the mother to prevent heat loss.				
5. POSITION: With head slightly lower than body to drain fluids from air passage;				
• Hold or lay baby on mother or bed;				
• With head slightly extended (sniffing position) to keep the air passage open.				
6. SUCTION: Clean the mouth, throat, and nose with finger/cloth/gauze; use suction bulb if available:				
• Before delivery of body.				
• After delivery.				
• Use suction correctly.				
7. STIMULATE: Gently rub the back with your hand while you are drying the baby.				
8. After you dry, warm, position, suction and stimulate the baby. LOOK, FEEL, AND LISTEN:				
	Date	Date	Date	Date
• Breathing				
• Heart rate				
9. FINDINGS I: skin color blue, breathing present, heart rate above 100.				
ACTIONS I: RESUSCITATION				
• Continue stimulation.				
• Give oxygen, if available.				
• Check breathing and heart rate.				
• When skin color is pink, put baby to breast.				
10. FINDINGS II: skin color blue or pale, breathing absent, heart rate below 100.				

ACTIONS II: BREATHING RESUSCITATION				
• Keep the airway open (sniffing position).				
• Give oxygen, if available.				
• Place gauze over mouth if available and start breathing for the baby.				
- Place your mouth over baby's mouth and nose.				
- Breathe 1 time, using air only from your mouth and watch to see chest rise.				
- If the chest does not rise, reposition, suction again, and try another breath, then recheck breathing.				
• When the chest rises, LOOK to see if baby is trying to breathe on its own.				

	Date	Date	Date	Date
• If the baby is breathing : continue to warm, stimulate and give oxygen until the baby is pink and crying.				
• If the baby is not breathing :				
- Breathe 5 times (short, fast and gentle) for the baby.				
- LOOK for breathing (respirations).				
- FEEL/LISTEN for heart beat.				
- Continue until baby breathes and heart beats more than 100 times in a minute.				
- Continue until baby is pink and crying OR strong enough to REFER.				
11. FINDINGS III : breathing absent, heart rate absent or below 80 beats in a minute.				
ACTIONS III: FULL CARDIOPULMONARY RESUSCITATION				
• Keep the airway open (sniffing position).				
• Give oxygen, if available.				
• Place gauze over baby's mouth if available and start breathing for the baby.				
- Place your mouth over baby's mouth and nose.				
- Breathe 1 time, using air only from your mouth and watch to see chest rise.				
- If chest does not rise, reposition, suction again, and try another breath. LOOK to see the chest rise.				

• When the chest rises:				
	Date	Date	Date	Date
- Place your index and middle fingers over the heart (center of the chest, just below the nipple line).				
- Push the chest down 1.5 cm ($\frac{1}{2}$ to $\frac{3}{4}$ inch) counting 1 and 2 and 3 and 4 and 5 and ...				
- Breathe on the 6th count. Do not lift your fingers off the baby's chest while you breathe.				
- Complete the CPR CYCLE of 5 beats and 1 breath, 5 times; then recheck baby's breathing and heart rate.				
• If there is still no heart beat or breathing , continue full CPR for at least 15 to 30 minutes or until the baby has a heart rate above 80 or is breathing.				
• If there is a heart beat above 80 :				
- Stop doing heart compressions.				
- Continue breathing until baby is breathing on its own.				
- Continue to warm, give oxygen, stimulate until baby is pink.				
• REFER.				
12. Do APGAR scoring at 1 and 5 minutes.				
• A ppearance - LOOK				
• P ulse - FEEL & LISTEN				
• G rimace - FEEL & LOOK				
• A ctivity - LOOK & FEEL				
• R espirations - LOOK				
	Date	Date	Date	Date
• TOTAL THE SCORE AND RECORD				
13. Care for the cord.				
14. LOOK at condition of the baby.				
• Keep warm.				
- Have the baby sleep with mother.				
- Cover baby with a dry cloth.				
• Air passages clear.				
- Wipe any fluids.				
- Place baby on side to sleep.				

- Nutrition - colostrum through sucking or expression

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Comments:

**Skills Checklist - Adult
Resuscitation**

	Date	Date	Date	Date
Airway - make sure the airway is open				
1. Speak to the person				
<ul style="list-style-type: none"> • ASK: "Are you all right?" 				
<ul style="list-style-type: none"> • Call for help. 				
2. Speak to the person				
<ul style="list-style-type: none"> • ASK: "Are you all right?" Roll her onto her back. 				
<ul style="list-style-type: none"> • Roll her over as a unit so her whole body rolls at the same time. 				
<ul style="list-style-type: none"> • Ask for help from anyone who may be close by. 				
3. Speak to the person				
<ul style="list-style-type: none"> • ASK: "Are you all right?" Look into her mouth to make sure the airway is open. 				
4. Clear the nose and mouth with your fingers of anything you can see or feel.				
5. Move the head into a position that will prevent the tongue from falling into the throat.				
<ul style="list-style-type: none"> • Place one hand on the person's forehead and press firmly backward. 				
<ul style="list-style-type: none"> • With your other hand, press the fingers under the jaw near the chin; lift the chin forward until the teeth are almost closed. 				
<ul style="list-style-type: none"> • If the person has loose false teeth, remove them. 				

	Date	Date	Date	Date
Breathing - make sure the person is breathing				
6. Look at the person's chest. Now that the head is in a position where the tongue is not blocking the airway, the person may begin to breathe on her own.				
7. If she is not breathing, quickly kneel at her side.				
<ul style="list-style-type: none"> Pinch her nose closed with your fingers and breathe into her mouth. 				
<ul style="list-style-type: none"> If air does not enter, adjust the position of her head and try again. 				
<ul style="list-style-type: none"> Does the air enter her chest easily? 				
<ul style="list-style-type: none"> If not, do the Heimlich maneuver. 				
<ul style="list-style-type: none"> Then clear the mouth and nose again, reposition the head, and breathe again. 				
<ul style="list-style-type: none"> Try to breathe into the person again. 				
<ul style="list-style-type: none"> Take a breath after each breath you blow into the person. 				
Cardiac Function - make sure the heart is beating.				
8. After giving 2 quick breaths, check to see if the heart is beating. Feel for the person's pulse (heartbeat) on her neck at the carotid pulse.				
9. If the person has a pulse, do not do cardiac compressions.				
10. If the person has a pulse, but is not breathing , do only respiratory resuscitation. Breathe into the person's mouth approximately 12 times per minute (once every 5 seconds).				
11. If the person does not have a pulse, breathe for her and help her heart to contract.				

	Date	Date	Date	Date
12. Feel on the person's chest for the bottom of her rib cage (bottom of the sternum or xiphoid process).				
<ul style="list-style-type: none"> Place the palm (heel) of your hand above the bottom of the rib cage. 				
<ul style="list-style-type: none"> The heel of your hand is on the lower half of the sternum. 				
<ul style="list-style-type: none"> Place your other hand (either made into a fist or with fingers stretched) on top of your bottom hand. 				
<ul style="list-style-type: none"> Keep your arms straight with your elbows locked. 				
<ul style="list-style-type: none"> Press straight down over your hands. 				
13. As you lean forward, press the chest 4-5 cm (1½ to 2 inches).				
<ul style="list-style-type: none"> Press down and release for equal time (set a rhythm). 				
<ul style="list-style-type: none"> Do not stop (pause) between compressions. 				
<ul style="list-style-type: none"> Do not lift your hands up off the chest. 				
<ul style="list-style-type: none"> Compress the heart at 80 to 100 beats per minute. 				
<ul style="list-style-type: none"> Count one and 2 and 3 and 4 and 5, up to 15. 				
14. After 15 compressions, stop and give the person 2 breaths.				
<ul style="list-style-type: none"> Pinch the nose and keep the head in its slightly tipped back position. 				
15. After the 2 breaths, locate the proper hand position on the chest and give 15 more compressions.				

	Date	Date	Date	Date
<ul style="list-style-type: none"> Keep repeating the pattern of 15 compressions followed by 2 breaths. 				
<ul style="list-style-type: none"> Do 4 or 5 complete cycles in one minute. 				
16. After a minute or so, stop and recheck the person's carotid pulse.				
<ul style="list-style-type: none"> If she has a heart beat, look to see if she is breathing on her own. 				
<ul style="list-style-type: none"> If there is no heart beat and no breathing, continue with the cycle of 15 compressions and 2 breaths. 				
<ul style="list-style-type: none"> If there is a heart beat but no breathing, continue with the breathing at the rate of about 12 times per minute. 				
17. Get someone around you to help relieve you.				
<ul style="list-style-type: none"> Get someone around you to organize transportation. 				
<ul style="list-style-type: none"> Travel with her to the hospital for further care. 				
18. Shock - make certain the person is kept warm.				
<ul style="list-style-type: none"> Wrap her in a blanket or dry cloths while resuscitating her. 				

Comments:

Skills Checklist - Using a Vacuum Extractor

	Date	Date	Date	Date
Using a vacuum extractor:				
1. LOOK and FEEL for conditions necessary for using a vacuum extractor:				
• Term (full size) baby.				
• Baby alive or heart stopped during labor.				
• Full dilatation.				
• Vertex presentation.				
• Ruptured membranes.				
• No cephalopelvic disproportion no molding or caput, descent 1/5 or 0/5.				
• Contractions present.				
2. Explain to mother and family what you are going to do, why you are doing it, and how it will help her.				
3. Prepare delivery and vacuum extraction equipment.				
• Test vacuum extractor on palm of your hand.				
4. Be sure bladder is empty (have mother urinate or catheterize her).				
5. Position mother on her back, at edge of table/bed.				
6. Do vaginal examination to decide baby's position again.				
7. Dry baby's scalp.				
8. Apply the cup.				
• Separate labia.				

	Date	Date	Date	Date
• Pull perineum down.				
• Hold cup.				
• Insert cup down and in.				
• Press cup against scalp of baby.				
• Check for maternal tissue under cup.				
9. Raise the pressure.				
• Recheck for absence of maternal tissue under cup.				
• Never exceed recommended maximum pressure for your type of vacuum extractor.				
10. Pull fetal head through pelvis with contraction. Use correct direction of pull depending on level of head:				
• Before head clears symphysis pubis, pull down.				
• When the head is clearing the symphysis pubis, pull straight out.				
• When head crowns, pull up.				
11. When the contraction stops:				
• Reduce pressure (unless using Malmstrom vacuum extractor).				
• Do not pull.				
• Encourage mother to breathe slowly and relax.				
• Check fetal heart rate.				
12. Repeat 10. and 11. above until head crowns.				
13. Deliver head of baby.				

Date Date Date Date

14. Release pressure.				
15. Complete the delivery.				
16. Care for mother and baby.				
17. Care for vacuum extractor:				
<ul style="list-style-type: none"> To wipe off vacuum extractor, use soft, clean cloth dampened with decontamination fluid. 				
<ul style="list-style-type: none"> If fluids are in pump, clean by pumping warm water through pump. Clean pump quickly after birth so that blood does not clot in pump. Use infection prevention steps. 				
<ul style="list-style-type: none"> Dry pump by pumping air until equipment is dry inside. 				
<ul style="list-style-type: none"> If cup and tubing are reusable, decontaminate, wash with soap and water, rinse, and dry, and sterilize. 				
<ul style="list-style-type: none"> Store assembled vacuum extractor in clean, dry, and covered area. 				

Comments:

**Skills Checklist-
Symphysiotomy**

	Date	Date	Date	Date
When you do a symphysiotomy:				
1. LOOK and FEEL for signs of CPD				
• Decent of fetal head.				
- Engaged.				
- 2/5 or less felt abdominally.				
- Molding + or ++.				
• Dilation of cervix 7 cm or more.				
2. Collect all of your equipment.				
3. Explain and show your assistants what to do.				
• The first assistant watches IV, monitors mother and baby.				
• The second assistant is gloved to assist.				
• Two reliable persons hold the woman's legs.				
4. Explain to mother and family what you are doing.				
5. Ask first assistant to wash the lower abdomen and genital area with soap and water.				
6. Start an IV infusion, if it is not already running.				
7. Ask 2 reliable persons to help the woman lie on her back.				
8. Scrub and glove.				
9. Infiltrate 10 ml 1.0% lidocaine hydrochloride into the skin over and around symphysis pubis.				
10. Infiltrate perineum with 10 ml of 1.0 % lidocaine hydrochloride.				

	Date	Date	Date	Date
11. Pass a catheter.				
12. Ask the 2 reliable persons to support the legs against their chests so that the legs are abducted (pulled apart) to not more than 80 to 90 degrees.				
13. Check to make sure the anesthesia is working by touching a sharp needle to the area.				
14. Get ready to make the incision:				
• Insert two fingers into the vagina.				
• Find the catheter/urethra with vaginal fingers.				
• Push the catheter to one side.				
• Find the symphysis pubis with the vaginal fingers.				
15. Start the incision:				
• Feel for symphysis pubis fibrocartilage.				
• Insert scalpel in the mons over symphysis pubis.				
• Make ¼ inch (½ cm) incision.				
• Keep catheter pushed to one side with vaginal finger to protect the urethra.				
• Place the other vaginal finger at the back of the symphysis pubis joint to feel for knife blade.				
16. Finish the incision:				
• Hold the scalpel at a right angle to the skin and symphysis pubis.				

	Date	Date	Date	Date
<ul style="list-style-type: none"> Keep the cutting edge pointing towards you. 				
<ul style="list-style-type: none"> Push knife firmly and smoothly through the fibrocartilage. 				
<ul style="list-style-type: none"> You will feel the blade more easily with vaginal fingers a cartilage is cut. 				
<ul style="list-style-type: none"> You should always feel tissue between vaginal fingers and knife blade. 				
<ul style="list-style-type: none"> Your vaginal fingers will feel about a 2.5 cm (width of thumb) separation of the pubic bones. 				
17. If there is bleeding, stop it with direct pressure.				
18. Let the fetal head decide the amount of separation of the symphysis pubis.				
<ul style="list-style-type: none"> Ask reliable persons to adduct (put together) woman's legs after incision. 				
<ul style="list-style-type: none"> Ask reliable persons to watch for bleeding and tell you right away. 				
19. Prepare for delivery:				
<ul style="list-style-type: none"> Make a generous episiotomy. 				
<ul style="list-style-type: none"> Use vacuum extractor if woman can not push baby. 				
20. Deliver the baby:				
<ul style="list-style-type: none"> Be prepared for a depressed baby. 				
21. Give oxytocic and do active management of third stage.				
22. Inspect vagina and cervix for trauma.				
23. Repair episiotomy and symphysis cut:				

Date Date Date Date

• Keep the legs as close together as possible.				
24. Change catheter to a Foley, if available.				
25. Bathe the woman, wrap her legs together, make her comfortable.				
• Place soft cloth between her knees.				
• Wrap legs loosely together so that she does not forget to keep them together.				
• Do routine after delivery care.				
• Check the catheter.				
26. Arrange for transport to hospital:				
• Go with the woman and her family.				

Comments: