FOGSI 2021-22
NAIPUNYA - SKILL FOR ALL
Course for Nurses & Paramedical Staff
17th November 2021 | 4:30 pm - 6:00 pm

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Skill development module on Intrapartum care

Dr Ponnuru Malathi. MD .FICOG
Expert member.
9 months of good care BUT one day of poor care intrapartum can result in bad outcomes.

YOUR SKILLS MATTERS .... TO HER & HER FAMILY.

270 days of care = 1 day of intrapartum care.
Objectives

1. Assess mothers risk by Triage at admission
2. Assess and interpret maternal vitals
3. Discuss on safe practices
4. Describe and interpret parameters of partograph
5. Describe conduct of safe delivery.
Triage every mother by ALLOTTING CLOUR CODE.

WHY CLOUR CODE?
Guides you on what is next.

See immediately, give first aid, manage or refer based on facilities.

See, monitor closely & manage or refer based on facilities.

See, manage & follow the protocols.

ALLOT CLOUR CODE
MANAGE MOTHER AS PER THE COLOUR CODE.
Check point I - At admission

ALLOT COLOUR CODE
CHECK Mother’s History in MCP | Antenatal card

❖ Height - Short - < 145cms
❖ Weight /BMI - High
❖ Previous cesarean surgery
❖ Previous baby died
❖ More than one baby inside - twins
❖ Epilepsy - taking medicines for fits
❖ Asthma – taking medicines for breathing problem
❖ Diabetes – taking medicines for high blood sugar
❖ Heart related problem
❖ High blood pressure
❖ Tuberculosis – taking medicines now
❖ HIV tested positive | taking drugs
❖ COVID test Positive | took medicines recently or taking now | suspected case

If YES TO ANY ONE
Check point I  - At admission

ALLOT CLOUR CODE

Examine Mother

❖ Pale eyes – Anaemia
❖ Yellow eyes -Jaundice
❖ Temperature > 38 deg C – fever
❖ Pulse rate >100/minute
❖ Breathing fast- Respiration rate >24/minute
❖ Oxygen Saturation< 94%
❖ High BP =/ >SBP 140 or DBP 90mmHg
❖ Low BP SBP <90 DBP< 60 mm Hg
❖ Swollen legs, hands & face

❖ Bleeding per vagina
❖ Leaking water per vagina >16 hours
❖ Labour pains stopped suddenly
❖ Uterus bigger in size (more than one baby, more fluid, big baby ) | smaller in size (less fluid, small baby )
❖ Uterus shape like peanut | not oval and long
❖ Early labour 6 wks before due date - preterm |
   crossed due date - Post term
❖ No fetal movements | less movements

If YES TO ANY ONE

See immediately, give first aid, manage or refer based on your facility.
### Why maternal vitals are important?

<table>
<thead>
<tr>
<th>Vital</th>
<th>Features</th>
<th>Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Temperature</strong></td>
<td><strong>Low- cold hands &amp; feet</strong></td>
<td>Shock</td>
</tr>
<tr>
<td></td>
<td><strong>High – hot</strong></td>
<td>**Sepsis</td>
</tr>
<tr>
<td>Pulse rate</td>
<td>Slow, weak, not felt or very fast</td>
<td>Shock</td>
</tr>
<tr>
<td>Respiratory rate</td>
<td>Oxygen saturation</td>
<td>Not able to talk 2-3 sentences</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Breathing problem</td>
</tr>
<tr>
<td>BP</td>
<td>Low SBP&lt;90 mmHg</td>
<td>Shock</td>
</tr>
<tr>
<td></td>
<td>High BP SBP =/&gt;140mmHg</td>
<td>Throw fits, bleeding in the uterus or head, heart failure &amp; baby death.</td>
</tr>
</tbody>
</table>
CHECK LIST FOR BP RECORDING

Ref to VIDEO 1 for checking BP in sitting position.

Normal BP
SBP 90-120 mm Hg
DBP 60-80 mm Hg

High BP
SBP 140 or > / DBP 90 or > mmHg

- Explain mother
- Both feet resting on floor
- Back rest
- Check cuff size
- Tie 2 fingers above elbow
- Check tightness
- Palpate radial pulse
- Check with stethoscope
- Release slow 2mm speed
- Sounds appear – SBP
- Sound disappear / muffles – DBP
- Inform mother
- Document.
CHECK LIST FOR TEMERATURE RECORDING

Ref to VIDEO 2 for checking Temp in arm pit.

Normal temperature
98.6 °F / 37°C
Ref to Video 3
Steps for checking oxygen Sat & Pulse rate

Dos & Donts for checking Oxygen sat & Pulse rate

<table>
<thead>
<tr>
<th>Warm fingers</th>
<th>Remove nail polish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Place it correctly</td>
<td>Sit calmly</td>
</tr>
<tr>
<td>Index finger</td>
<td>Top Oxygen sat Bottom Pulse rate</td>
</tr>
</tbody>
</table>

Normal oxygen saturation - 95-100%
Normal pulse rate 60-100/minute
Steps for checking urine protein & sugar at admission

1. Two channel strip
2. Multichannel strip
3. Protein top
4. Sugar bottom
5. Fresh sample
6. Dip the tip for 30 sec
7. Remove excess urine
8. Colour match
9. Inform mother
10. Document

Ref to Video 4
Checking of urine protein & sugar.
### Check list for labour delivery recovery room - Keep Trays ready

<table>
<thead>
<tr>
<th><strong>Delivery tray</strong></th>
<th><strong>Episiotomy tray</strong></th>
<th><strong>Baby tray</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Instruments</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Kidney tray -1</td>
<td>• Kidney tray -1</td>
<td>• Warm towels -2</td>
</tr>
<tr>
<td>• Sponge holder -1</td>
<td>• Episiotomy scissors -1</td>
<td>• To receive &amp; dry -1</td>
</tr>
<tr>
<td>• Small steel bowl -1</td>
<td>• Artery forceps -2</td>
<td>• To wrap -1</td>
</tr>
<tr>
<td>• Scissors -1</td>
<td>• Alleys forceps -2</td>
<td>• Mucous sucker -1</td>
</tr>
<tr>
<td>• Speculum large size -2</td>
<td>• Straight artery -2</td>
<td>• Penguin shape</td>
</tr>
<tr>
<td>• Long straight artery forceps - 2</td>
<td>• Needle holder -1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Thumb forceps -1</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Scissors -1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Sterile gloves -2 sizes 3 pairs</td>
<td>• Xylocaine vial 2% -1</td>
<td>• Bag &amp; mask -1</td>
</tr>
<tr>
<td>• Sterile gauze pads -6</td>
<td>• Check expiry date</td>
<td>• Check working condition</td>
</tr>
<tr>
<td>• Cotton balls -6</td>
<td>• Distilled water -2</td>
<td></td>
</tr>
<tr>
<td>• Perineal Pads -3</td>
<td>• 10 cc syringe -1</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cord clamp -1</td>
<td>• Vicryl rapide 1-0 - 2</td>
<td>• Vitamin K injection 1mg – check expiry date</td>
</tr>
<tr>
<td>• Urinary catheter -1</td>
<td></td>
<td>• Insulin syringe -1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Sterile cotton swab</td>
</tr>
</tbody>
</table>

**Additional trays -**  PPH TRAY, ECLAMPSIA TRAY
**Medicine Tray**

**Keep in fridge at 2-4 deg**

1. Oxytocin ampoules
2. Methergine ampoules
3. Prostadin ampoules
4. **Keep in labour room**
   1) Tab Misoprostol 600mg -1|200mg -4
   2) Tab Nifedipine -10mg –one strip
   3) Diclofenac rectal suppository
   4) Tab Paracetamol –one strip.

**Sponge holder**

**Episiotomy scissors**

**Thumb forceps**

**Bag & mask**

**Needle holder**

**Mucous sucker**

**Penguin shape**
Check point 2 – at admission

Why shape of Mothers abdomen is important?

OVAL
Round head down
Seedha

OVAL
Broad buttocks down
Ultaa

Aadda
OVAL TRANSVERSELY

Aadda
OBLIQUE
Why shape of Mothers abdomen is important?

PEANUT SHAPE - OBSTRUCTED LABOUR
ATTAK GAYA
Check list for Examination of mothers abdomen in labour.

- Explain
- Ask to pass urine
- Expose
- See the shape
- Bring uterus to the middle
- Top – check the part
- Side – Check baby back | limbs
- Down – Check head | buttocks
- Be gentle
- Check babies heart beat on the side of its back first with stethoscope then hand doppler
- Inform mother
- Document.

Ref to Video 5
Demonstration of Abdominal examination in labour.
Check list for listening to fetal heart in labour

- Why to check?
  To know babies condition

- When to check?
  When pain goes away

- Why not during pain
  Mother will not allow you to check.

- Where to check?
  On the babies back

- For how long?
  For one minute

- What is Normal?
  110-160 beats per minute
How to understand babies' condition by matching with the fluid colour?

Green Fluid looks like palak juice

Red Fluid looks like tomato juice

Clear Fluid looks like coconut water

Call the doctor immediately

Call the doctor immediately

Continue monitoring
Check list for vaginal examination

1) Explain mother
2) Wash both hands - 6 steps for 2 minutes or alcohol rub
3) Wear sterile gloves on both hands
4) Clean the outer parts with betadine swab
5) Clean the central part with betadine swab
6) Wet examination fingers with betadine
7) Pass your two fingers gently
8) Inform mother
9) Document
How to learn cervical dilation?

1 finger = 1 cm

2 fingers = 2 cms

2 fingers + 1 finger space = 3 cms

Starts making angle = 4 to 9 cms. Cervix felt.

Fingers move widest 10 cms = full dilatation. Cervix not felt.
**Early labour till cervix opens by 4 cms- 1st Stage of labour**

- Monitor Mother
  - Pulse rate Every 1 hour
  - Temperature, BP every 4 hrs (If high every 30 minutes)

- Monitor baby heart rate every 1 hour
  - Colour of liquor (check stain on diaper)

- Monitor labour progress every 1 hour
  1. Contractions – number, duration in sec every 10 minutes
  2. Cervical dilatation
  3. Head coming down

**Active labour from 4 cms to full opening of cervix by 10 cms - 1st Stage of labour**

- Monitor Mother
  - Pulse rate every 30 minutes
  - Temperature, BP every 4 hrs. (If high every 30 minutes)

- Monitor baby every -30 minutes
  - Heart rate (in high risk every 15 min)
  - Colour of liquor (check stain on diaper)

- Monitor labour progress at 4hrs
  1. Contractions – number, duration in sec every 10 minutes
  2. Cervical dilatation
  3. Head coming down

**In active labour from full dilatation till delivery – 2nd stage**

1. Monitor mother and baby heart rate
   - Every 15 min
   - Every 5 min if high risk
2. Contractions – number, duration in sec every 10 minutes
3. Head coming down

**DOCUMENT IN THE CASE RECORD**

**PLOT IN THE PARTOGRAPGH AND INTERPRET**
Partograph showing normal progress of labour

Contractions 1-5 number

...... Weak < 19 sec
/// Moderate 20 – 40 sec
■ Severe > 40 sec

Normal fetal heart rate 120-160/min

Delivery notes

Mother PR BP Temp

Cervical dilatation line
Staying to the right of alert line – Normal
Partograph showing Abnormal progress of labour

Cervical dilatation line crossing alert or action line is abnormal.

Fetal heart rate dipping below 120/min – abnormal

Normal fetal heart rate 120- 160/min

Cervical dilatation Crossing both alert & action line Abnormal

Alert line

Action line

/// 3 contractions Moderate 20 – 40 sec

3 - 4 contractions Severe > 40 sec

Inform doctor immediately, manage or refer based on your facility.
<table>
<thead>
<tr>
<th><strong>DO’s</strong></th>
<th><strong>DONTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hand over jewellery to the attendant &amp; take signature in record</td>
<td>• No enema</td>
</tr>
<tr>
<td>2. Change to hospital clothes</td>
<td>• No shaving</td>
</tr>
<tr>
<td>3. Provide mask to mother &amp; her attendant</td>
<td>• No routine IV fluid Only RL</td>
</tr>
<tr>
<td>4. Labour room Temperature 22 - 26 deg C</td>
<td>• No IV 5% Dextrose</td>
</tr>
<tr>
<td>5. Shut windows</td>
<td>doors</td>
</tr>
<tr>
<td>6. Check functioning status of Suction apparatus</td>
<td>Ambu bag</td>
</tr>
<tr>
<td>7. Foot stepper</td>
<td>• Do not shout at mother</td>
</tr>
<tr>
<td>8. Fix Intra cath - Green colour</td>
<td>• Do not leave mother alone</td>
</tr>
<tr>
<td>9. Draw X matching sample, label &amp; send to Blood bank</td>
<td>• Do not carry cell phone inside -use land line for communication</td>
</tr>
<tr>
<td>10. Keep trays and Partograph paper ready</td>
<td>• Do not allow to take pictures of mother or baby.</td>
</tr>
<tr>
<td>11. Load Oxytocin 2 ampoules label &amp; put in fridge-4deg</td>
<td></td>
</tr>
<tr>
<td>12. Identify - Birth Companion to Walk, Talk &amp; Support the mother</td>
<td></td>
</tr>
<tr>
<td>13. Take her to labour room when cervix opens by 4cms or more.</td>
<td></td>
</tr>
</tbody>
</table>
**Right way of handling baby**

1. Receive in warm towel (one)
2. Place baby flat on mothers abdomen
3. Dry the baby (not cleaning)
4. Remove towel one
5. Cover the baby in warm towel (Two)
6. If not crying cut cord and place the Baby flat under the warmer, position it & start ventilation.

**Wrong way of handling baby**

1. Holding baby upside down
2. Beating the babies back
3. Shaking the baby
4. Removing vernix while drying
5. Rubbing oil on babies body
6. Applying powder | oil | spirit | betadine to the cord stump.
7. Feeding baby with honey | holy water
8. Handing over the baby to attendants.
How to deliver head safely?

Right hand supports the perineum
Left hand supports the baby's head
Why both hands? To prevent tears

Receive baby in a warm towel
Place on mother's abdomen
Dry the baby and change the towel
Don't suction if baby is crying

Tell mother & give 10 IU Oxytocin on the thigh.
Cut cord after pulsations stop.
Support breast feeding.

Crowning stage

Anus open
Bulge seen
Head seen

Check list for conducting vaginal delivery

Ref to Video 7 demonstration of conducting vaginal delivery
How do deliver placenta?
1. Push uterus up
2. Pull cord gently down
3. Twist the membranes
4. All this only when uterus is felt hard

Placenta needs both examination & disposal
1) **See me** - Pehle dhono tharaaff Dhekoo - both sides. Hang placenta to see the membranes
2) **2 Veins + 1 Artery-smilie**
3) **Throw me** - Baadh mein Phenkoo

* Document notes with the names of attending staff conducting delivery.
### Do’s

1. Change positions - sitting | standing | squatting
2. Allow oral fluids - water | juice | coconut water | soup
3. Encourage her to pass urine every 2 hours
4. Keep 2 clean warm towels for baby
5. One for receiving & drying, other for wrapping the baby.
6. One Nurse must call out time & sex of baby.
7. Start breast feeding immediately.
8. **AFTER DELIVERY**
9. Check for hardness of uterus and vaginal bleeding
10. Show the baby to the attendant take signature, full name & relationship.
11. Give Vitamin K to the baby IM on the thigh
12. Check Pulse, bleeding if light or heavy for next 2 hours in labour room.
13. Mother must be able to eat, drink and walk comfortably by 2hrs.
14. Shift mother with baby to the ward only after doctor checks her Pulse, BP, vaginal bleeding & baby condition.
15. Keep the case records safe.

### Don’ts

1. No lying down with legs up
2. No pushing unless mother feels
3. No pressure on the top of uterus
4. No steel tray for baby
5. No suction if baby is crying
6. No cutting of cord immediately if baby is crying
7. Do not apply anything to the cord
8. Do not leave mother and baby alone.
9. Do not wipe vernix – white coating or give bath.
10. Do not check baby weight immediately
11. No honey for the baby only mothers milk
12. Do not keep baby nude any time.
**Check point 3 How to dispose safely?**

Match the product with bin

<table>
<thead>
<tr>
<th>PLACENTA</th>
<th>Gloves</th>
<th>glove cover</th>
<th>Perineal pads, under drapes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syringe</td>
<td>Plastic cover</td>
<td>Ampoules</td>
<td>PPE Kit – gown, mask, leggings, Goggles</td>
</tr>
<tr>
<td>Cotton swabs</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Needle</th>
<th>IV set/Saline bottle</th>
<th>Instruments</th>
<th>floor spill-blood or body fluids</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urine Catheter</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PLACENTA</td>
<td>Gloves</td>
<td>Perineal pads</td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>---------</td>
<td>---------------</td>
<td></td>
</tr>
<tr>
<td>Yellow bin</td>
<td>Red bin</td>
<td>Yellow bin</td>
<td></td>
</tr>
<tr>
<td>Syringe</td>
<td>PPE Kit</td>
<td>Cotton swabs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Plastic cover</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ampoules</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gown, mask, leggings, Goggles</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PLACENTA</th>
<th>Under drapes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Yellow bin</td>
<td>Yellow bin</td>
<td></td>
</tr>
<tr>
<td>Syringe</td>
<td>IV set - Red bin</td>
<td>Cotton swabs</td>
</tr>
<tr>
<td>Red</td>
<td>Gloves -Red bin</td>
<td></td>
</tr>
<tr>
<td>Glove cover</td>
<td>Plastic cover of syringe-</td>
<td></td>
</tr>
<tr>
<td>Goggles</td>
<td>Saline bottles</td>
<td>PPE Kit -gown, mask, leggings</td>
</tr>
<tr>
<td>Needle</td>
<td>Broken ampoules</td>
<td>Urinary Catheter-Red bin</td>
</tr>
<tr>
<td></td>
<td>Floor spill-blood/liquor</td>
<td>Instruments – O.5%Chlorine for 10 min</td>
</tr>
</tbody>
</table>
FEEDBACK HELPS U TO UNDERSTAND WHERE U STAND.

Thank You

Thanks for always listening to me, supporting me, and encouraging me. You’re a true friend, and I want you to know how much I love and appreciate you. You’re the best!