



MINISTRY OF HEALTH
Government of Trinidad and Tobago

Standard Operating Procedure Manual for
**Obstetric and
Midwifery Services**

June 2011



The Office of the Chief Medical Officer and
The Directorate of Health Services Quality Management



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MINISTRY OF HEALTH

FOREWORD

The Ministry of Health has taken the decision to implement Standard Operating Procedures for all health care services both public and private, as an approach to standardizing the guidelines for health care practitioners to ensure efficiency and effectiveness while securing safety in the care delivered. This approach assists practitioners to meet an acceptable standard of best practice for all procedures each and every time.

The Standard Operating Procedures Manual for Obstetric and Midwifery Services was developed in accordance with the Accreditation Standards Manual for the Health Sector with the involvement of health care practitioners from the public and private health sector wherever obstetric and midwifery services are offered.

The manual promotes universal access to care, privacy and confidentiality and client safety as pillars for ensuring that every pregnant woman seeking obstetric and midwifery services in Trinidad & Tobago will receive quality antenatal, intrapartum and postnatal care. Consideration will also be given to ensuring that clients receive an integrated and holistic approach to Midwifery and Obstetric care.

Pain in labour is expected and anticipated. This added to the fear that some clients experience leads to much anxiety. Antenatal education and pain relief have become a major factor in preparing clients for childbirth and reducing the anticipated anxiety. The manual therefore has considered the various approaches which can be used to assist the client through the birth of the baby.

The Ministry requires that the management of each facility offering obstetric care would develop strategies to ensure implementation of the manual in the particular unit. Systems should also be introduced to facilitate monitoring for compliance in the use of the manual.

Caring for a pregnant woman could be very complex since care is being delivered to both the client and the fetus and the outcome may not always be favourable. When these instances occur, the situation can be very traumatic for the client, family members and staff involved. The Manual therefore prescribes approaches designed to achieve positive outcomes for mother and newborn and addresses situations where the outcomes have been unfavourable.

Obstetric care does not always have a positive outcome; when these instances occur, the situation can be very traumatic, for the family members involved. The manual has included for Practitioners guidelines on the quality of care which should be extended to the bereaved parents and family at the time of loss.

ACKNOWLEDGEMENT

The Ministry of Health wishes to acknowledge the contribution of the Chief Medical Officer, the Adviser, Health Services Quality Management; the consultant obstetricians, the midwives of both the private and public health sector who contributed to the drafting of the document and participated in the review meetings and workshops which were held at each stage of the draft.

The Ministry also expresses sincere thanks to the other members of staff of the various RHAs who responded to the Ministry's request for comments on the draft Standard Operating Procedures for Obstetrics and Midwifery. The staff of the Directorate of Quality Management is commended for their logistical support to the committee.

Members of the SOP Obstetric Committee

Dr. Anton Cumberbatch	Chief Medical Officer, Ministry of Health
Mrs. Valerie Alleyne – Rawlins	Adviser, Health Services Quality Management
Ms. Deanna Miller	Standards Officer, Quality Management
Mrs. Ingrid Salandy – Allan	Health Care Protocol Officer, Quality Management
Dr. Adesh Sirjusingh	Medical Chief of Staff, S/Grande Regional Hospital
Dr. Wayne Haqq	Head, Obs/Gynae Mt. Hope Women's Hospital
Dr. Patrick Chauharja Singh	Head, Obs/Gynae POSGH (Ag)
Dr. Victor Wheeler	Head, Obs/Gynae, Scarborough Regional Hospital
Dr. Ashmeed Mohammed	Head, Obs/Gynae, SFGH
Mrs. Patricia Wharwood	Head Nurse, Labour Ward, POSGH
Ms. Dolores Ferguson	Head Nurse, Labour Ward, SFGH
Ms. Rookmin Pirmal	Head Nurse, Ante-Natal Ward, SFGH
Ms. Cecilia Hutson	Head Nurse, Labour & Delivery, MHWH
Ms. Alicia Ross	Head Nurse, Mat. Dept, S/Grande Hospital
Ms Thora Wilson	Quality Manager, TRHA
Ms. Frances Rodriguez	Head Nurse (Ag) Tobago Regional Hospital
Mrs. Marcia Rollock	Principal, School of Midwifery, POSGH
Mrs. Eureka Griffith	Principal, School of Midwifery, SFGH

ACCOUNTABILITY PAGE

1. Policies

This Standard Operating Procedure Manual for Obstetric and Midwifery Services was developed in accordance with the Ministry of Health’s Accreditation Standards Manual for the Health Sector (2002). It seeks to standardize the delivery of obstetric services at both public and private health care facilities. It was developed based on the Ministry of Health’s principles of accessibility, equity, affordability, efficiency, effectiveness and safety.

2. Control

The Executive Medical Directors, County Medical Officers of Health, Medical Directors, Chiefs of Staff, General Managers of Nursing, Primary Care Nurse Managers and Nursing Managers, the Medical Board, the Nursing Council and Heads of Departments of the respective health care facilities have the overall responsibility for the implementation of this manual.

3. Distribution

This Standard Operating Procedures Manual for Obstetric and Midwifery Services shall be distributed by the Directorate of Health Services Quality Management to all primary and secondary health care facilities (public and private) where obstetric and Midwifery services are provided.

4. Review Cycle

The Standard Operating Procedures Manual for Obstetric and Midwifery Services shall be reviewed by the Directorate of Health Services Quality Management and updated every three (3) years or more often if warranted.

APPROVAL

Adviser, Quality Management

Chief Nursing Officer

Chief Medical Officer

Permanent Secretary

Minister of Health

Approval Date: _____

Review Date: _____

INTRODUCTION

The Ministry of Health in its quest to improve health care delivery continues to develop strategies to improve the health sector. Obstetric and Midwifery services have been designated high priority because of the scope of care that is needed for each pregnant woman from confirmation of pregnancy to postpartum care. Special attention must be paid to the quality of service that is offered to ensure that there is a successful outcome to each pregnancy.

The World Health Organization since 2000 has been placing emphasis on maternal and infant mortality as one of its indicators of the quality of health care. Trinidad & Tobago has declared its commitment to the improvement of Obstetric and Midwifery care by ensuring that its maternal mortality rate remains with what is considered international standards.

In keeping with the millennium development goals (MDGs) established in 2000, the Ministry of Health in its output Indicators & Cost Matrix has identified as one of its goals, the reduction of the maternal mortality rate by sixty (60) percent and infant mortality rate by 70% by 2020. One approach towards achieving this goal is the development and implementation of the Standard Operating Procedures Manual for Obstetric and Midwifery Services.

The Standard Operating Procedures Manual for Obstetric and Midwifery services is intended to promote best practice, standardize, improve and sustain the quality of maternal & child health at both private and public health care facilities within Trinidad & Tobago. It was developed based on the Ministry of Health's quality principles of accessibility, equity, appropriateness, acceptability, efficiency, effectiveness and safety.

The Ministry of Health requires the Management of the Regional Health Authorities and the Private Hospitals to sensitize their staff to implement the Manual, and to establish systems for compliance.

The Scope of the Manual covers prenatal to postnatal services including loss and bereavement to ensure that families who experience an unfavorable outcome, would receive support care.

GENERAL POSITION/POLICY STATEMENTS

1. Universal Access to Care

In keeping with the Client's Charter of Rights and Obligations, each client seeking obstetric and midwifery services shall be afforded equal access to treatment and/or available lodging and appropriate obstetric, nursing/midwifery care based on identified needs and available resources. No client shall be denied access to obstetric and midwifery services at a public or private healthcare facility.

2. Privacy & Confidentiality

Each client receiving obstetric and midwifery care has the right to privacy during physical examination and history taking. All communication and records pertaining to treatment received shall remain confidential.

3. Client Safety

In keeping with the Client's Charter of Rights and Obligations, health care providers shall ensure that work systems, processes and practices are conducted in a manner which will promote and maintain client safety.

Adequate staff, space and equipment shall be provided for safe ante, intra and postnatal care at the obstetric department/unit.

4. Ethico-Legal Considerations

The attending Obstetrician and Licensed Midwife have joint responsibility for informing the client of all technical procedures including possibilities of any risk of death or complications.

Client shall not be subjected to any procedure without their voluntary informed consent, or that of their legally authorized representative; such consent should be procedure specific.

Clients shall be informed of any medical treatment alternatives and be given the option of choice. Informed consent shall be obtained if client agrees to participate in clinical programmes for the purpose of research in accordance with the Clients Charter of Rights & Obligations.

In the event of an adverse event, the disclosure clause of the adverse event policy shall apply.

5. Documentation & Record Keeping

Data received from the client and/or designated representative/s shall be accurately documented in the client's health record. This record must be maintained in accordance with the National Medical Records Policies and Procedures Manual. Client's health records and information are protected from loss, destruction, tampering and unauthorized access or use (MOI. 1.12).

6. Integrated Care

Appropriate support services at primary, secondary and tertiary levels shall be established and utilized to achieve an integrated and holistic approach to health care for the client and family.

7. Criteria for Referral

All pregnant women should access antenatal care as soon as pregnancy is confirmed. Referral to the secondary or tertiary care shall be dependent on the prescribed criteria. Admission to the antenatal ward shall be determined by a subsequent diagnosis of complications of pregnancy which may be life threatening to either mother or fetus.

8. Discharge Planning

The initial assessment of the antenatal client serves as a guide to the physical, psychological and social support that may be needed for postnatal care. In keeping with the National Admission, Transfer and Discharge Protocol, discharge planning for both mother and infant should commence on the client's initial visit to the Antenatal clinic.

9. Criteria for Referral

Referral of the pregnant client to a healthcare professional outside the organization to another health care setting is based on the client's health status and need for continuing care or services. An organized process is required to ensure that any continuing needs are met by the appropriate health care professional (ACC.3).

Referral shall be timely and appropriate to effectively meet the client's needs and achieve the expected outcomes.

MANAGEMENT OF THE OBSTETRIC / MIDWIFERY UNIT

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Management of the Obstetric/Midwifery Unit

REVIEW DATE :

Intent Statement: *Effective Management of the Obstetric/Midwifery Unit is critical to the delivery of care to the Obstetric client and the quality of care outcomes. It encompasses the establishment of systems for clinical governance, risk management including client safety and infection control and the implementation of standards of obstetric and midwifery best practice. The aim is for clients to have a safe, successful pregnancy, labour and delivery.*

The Department / Unit shall have -:

- 0.1 A Consultant Obstetrician who is appointed the Head of the Department with responsibility for obstetric services.
- 0.2 A Senior Midwife who is responsible for the management of midwifery and nursing services.
- 0.3 A complement of medical and midwifery staff that facilitates the delivery of safe, quality care.
- 0.4 Established written protocols and guidelines for the day to day management of the department/services.
- 0.5 Written clinical protocols for the delivery of obstetric care.
- 0.6 Written nursing/midwifery care protocols for the delivery of nursing and midwifery services.
- 0.7 A formal orientation programme for all new staff assigned to the department/ unit.
- 0.8 A formal programme of staff development for continuing education of all clinical /midwifery staff.
- 0.9 An established protocol for morbidity and mortality reviews
- 0.10 Established written protocols for the handover of clients at the completion of procedures and the changeover of shifts.
- 0.11 Established written protocols for obstetric rounds (case reviews).

- 0.12 Written protocols for the management of high risk clients.
- 0.13 A mechanism for collaborating with Human Resources Department for the completion of Performance Appraisals of staff.
- 0.14 A mechanism for ensuring that medical, nursing and midwifery staff acts in accordance with Legislation, Policies and Codes of Practice governing the professions.
- 0.15 Systems for re-assigning nursing, medical & midwifery staff to ensure clients' needs are properly addressed.

1.0 PHYSICAL ASSESSMENT & HISTORY TAKING

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Physical Assessment & History Taking

REVIEW DATE :

Intent Statement: *The History Taking and Physical Assessment of the pregnant woman is critical to the successful outcome of the pregnancy. It is also an opportunity to identify the needs of the pregnant woman which can be addressed in a timely manner. This activity is aimed at forming a baseline to assists in the early detection of complications.*

PROCEDURE

The Midwife shall:-

- 1.1 Obtain both subjective and objective data from the client/patient at the client's first ante-natal visit.
- 1.2 Document information on the client/patient present and past medical, surgical, social and family history present and past obstetric history and immunization status.
- 1.3 Document information on current risk factors including domestic violence.
- 1.4 Document behaviors such as cigarette smoking or the consumption of alcohol or drug abuse.
- 1.5 Document any socio-cultural and religious needs identified.
- 1.6 Conduct assessments of the client/patient at each clinic visit including the following:
 - Height in meters (first visit only)
 - Weight in kgs
 - Plot BMI
 - Urinalysis – glucosuria, proteinuria, ketonuria
 - Blood Pressure
 - Random blood glucose
- 1.7 Conduct a head to toe assessment including an abdominal palpation at each ante-natal

visit.

- 1.8 Conduct an assessment of the fetal heart rate at each visit.
- 1.9 Determine fetal lie, position and presenting part as appropriate.
- 1.10 Educate the client/patient on maternal and child health in preparation for labour and delivery.
- 1.11 Determine which blood samples are needed and the need for repeat testing as clinically indicated which may include:
 - Complete blood count
 - Blood group and Rhesus factor
 - Sickle cell test with hemoglobin electrophoresis if indicated.
 - VDRL
 - HIV screen
 - Hepatitis B Surface Antigen
 - Screening blood tests for diabetes mellitus.

The attending Obstetrician shall:-

- 1.12 Conduct assessment and screening on the client/patient.
- 1.13 Refer the client/patient to the appropriate discipline.
- 1.14 Request an ultra-sonogram to detect fetal gestation and any fetal and/or maternal abnormalities.

2.0 CLIENT EDUCATION

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Client Education

REVIEW DATE :

Intent Statement: *Education of the obstetric client is critical to the client during her pregnancy; the information she receives is expected to guide her to comply with all the advice given to her which could assure her of a successful pregnancy, labour and delivery.*

The Midwife or Health Visitor shall:-

- 2.1 Educate the client/patient seeking antenatal care on the importance of complying with the established clinic schedule as soon as pregnancy is diagnosed.
- 2.2 Assign the clinic appointments in accordance with the Maternal and Child Health Guidelines Manual of Trinidad and Tobago:-
 - Monthly until 28th week
 - Fortnightly until 36th week
 - Weekly until deliveryClinic schedule can vary based upon identified health needs of the woman.
- 2.3 Encourage family support and interaction during client visits.
- 2.4 Provide relevant information to the pregnant woman at various stages of her pregnancy including the following:
 - Nutrition
 - Childbirth education
 - Personal/dental hygiene
 - Exercises including pelvic exercises
 - Advice including smoking, recreational drug use, alcohol consumption and the use of over the counter drugs, herbal remedies
 - Signs of fetal life
 - Signs of Miscarriage
 - Signs of true labour
 - Preparation for confinement
 - Importance of compliance with prescribed medication

- Breast feeding management, techniques & benefits
- Contraceptive usage
- Signs of SROM (spontaneous rupture of membranes)
- Immunization schedule

Between 26-36 weeks

- Guidance for recognition of active labour
- Fetal activities/movements
- Care of the newborn
- Postnatal self care
- Awareness and management of postpartum blues and depression
- Postpartum psychosis

Between 38-42 weeks

The Obstetrician shall:

- 2.5 Provide the client/patient with options for mode of delivery where applicable.
- 2.6 Outline and update as necessary, the plan of care for the client.

The Midwife shall:-

- 2.7 Reinforce the signs of true labour.
- 2.8 Reinforce expectations during labour.
- 2.9 Advise the HIV positive client/patient to continue taking her Anti-retroviral medication as prescribed to reduce their viral load.
- 2.10 Remind the HIV client/patient to bring the Anti – retroviral medication when coming for admission to the labour ward and also that she should not breast feed.

3.0 INDUCTION / AUGMENTATION OF LABOUR

DEPARTMENT : Obstetric & Midwifery	EFFECTIVE DATE :
TOPIC : Management of patient having induction / augmentation of labour	REVIEW DATE :

Intent Statement: *Induction is the term used to start labour in a previously non – laboring woman. Augmentation is the term used when oxytocin is used to encourage progress when labour is slow. It is recommended practice in augmentation to first perform artificial rupture of membranes. The intention is to encourage steady progress which is safe but leading to the timely delivery of a healthy neonate.*

THE DECISION FOR INDUCTION IS TO BE MADE BY A CONSULTANT OR REGISTRAR.

3.1 INDUCTION WITH OXYTOCIN

PROCEDURE

The Obstetrician shall:-

- 3.1.1 Confirm the client's need for induction.
- 3.1.2 Confirm that other procedures tried have failed.
- 3.1.3 Assess the cervix for ripeness using a Bishop's Score.
- 3.1.4 Ensure that the choice of method for induction is documented in the health record.
- 3.1.5 Discuss with the client/patient the method of induction.
- 3.1.6 Ensure that there is a Cardiotocography (CTG) reading before introducing oxytocin.
- 3.1.7 Establish IV access to commence oxytocin regime.
- 3.1.8 Obtain a specimen of blood for Blood Count, Group & Cross-match.
- 3.1.9. Prepare oxytocin infusion and regime based on attached appendix.
- 3.1.10 Determine if the induction by oxytocin should be continued/discontinued.
- 3.1.11 Make a decision on change of management.

The Midwife shall:-

- 3.1.12 Monitor through CTG readings.
- 3.1.13 Monitor the client/patient's contractions, vital signs and well-being.
- 3.1.14 Conduct vaginal examinations to determine progress of labour and other obstetric findings.
- 3.1.15 Inform the Obstetrician of any progress /changes in the client/patient's condition.
- 3.1.16 Document all findings on the partogram. (See **Appendix II**)

3.2 INDUCTION WITH PROSTAGLANDIN USED WHEN THE CERVIX IS NOT "RIPE"

The Midwife shall:-

- 3.2.1 Ensure that the client/patient empties her bladder.
- 3.2.2 Establish baseline data.
- 3.2.3 Conduct the relevant non stress test.
- 3.2.4 Attach the Cardiotocography (CTG) machine to facilitate continuous monitoring.
- 3.2.5 Record all findings in the client/patient's health record.
- 3.2.6 Inform the Obstetrician immediately of any negative findings.
- 3.2.7 Conduct vaginal examination as indicated.
- 3.2.8 Assess the progress of labour at six (6) hours after insertion of Prostaglandin.
- 3.2.9 Communicate with the Obstetrician on the progress of labour.

The Obstetrician shall:-

- 3.2.10 Examine the client to confirm the need for induction with prostaglandin.
- 3.2.11 Ensure that a Non Stress Test has been conducted and is reactive.
- 3.2.12 Develop the relevant plan of care for the client.
- 3.2.13 Insert prostaglandin in the posterior fornix of the vagina.
- 3.2.14 Record the choice of method for induction in the health record.
- 3.2.15 Deliver the fetus in a timely manner if there is suspicion or confirmation of fetal compromise.

3.3. FAILED INDUCTION

The Obstetrician shall:-

- 3.3.1 Develop a definitive plan of management in the event of failed induction. This may include a further attempt to induce labour or a Caesarean Section.
- 3.3.2 Ensure that the plan of management is implemented in a timely manner.

3.4. COMMUNICATION

The Obstetrician /Midwife shall:-

- 3.4.1 Seek to provide relevant and appropriate information to the client/patient, their identified significant other and family in a timely manner.
- 3.4.2 Adhere to all guidelines as identified in the Ministry of Health's Infection Prevention and Control (IPC) Manual.

4.0 INTRAPARTUM CARE (Normal Labour)

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Intra – partum Care

REVIEW DATE :

4.1 Management of a client in the 1st stage of labour

Intent Statement: *Clinical and managerial leaders of the Obstetric Department/Unit plan and coordinate client care guided by written policies and procedures. Work systems ensure that all pregnant clients receive the appropriate Intrapartum care which results in the safe delivery of healthy newborn and mother.*

PROCEDURE:

The Midwife shall:-

- 4.1.1 Conduct a physical assessment including abdominal palpation on the client/patient.
- 4.1.2 Assess the vital signs and urine analysis of the client/patient.
- 4.1.3 Assess monitor and record the duration, frequency and intensity of uterine contractions.
- 4.1.4 Monitor the fetal heart rate to assess fetal well-being.
- 4.1.5 Monitor the client/patient's coping ability as labour progresses.
- 4.1.6 Offer, in accordance with National Guidelines, HIV screening.
- 4.1.7 Obtain (CTG) recording/s of fetal heart rate pattern of all high risk clients, inform the obstetrician on call and attach to client's records.
- 4.1.8 Conduct vaginal examinations.
- 4.1.9 Report immediately any abnormal signs, symptoms and findings to the Obstetrician.

- 4.1.10 Communicate the findings of her assessment to the client and/ or immediate family as appropriate.
- 4.1.11 Provide supportive care for the client/patient in terms of ambulation, nutrition, personal hygiene, breathing/relaxation techniques and general progress of labour.
- 4.1.12 Document all findings on the partogram.
- 4.1.13 Develop an individualized plan of care in collaboration with the client/patient.
- 4.1.14 Prepare client for delivery when labour is established and progressive.
- 4.1.15 Employ pain management techniques in accordance with established pain management protocols and guidelines.
- 4.1.16 Ensure that client's bowel and bladder are emptied.
- 4.1.17 Ensure that emergency equipment, medication and consumables are available and functional in preparation for delivery of the newborn.
- 4.1.18 Advise, support and assist the client during labour.

The Obstetrician shall:-

- 4.1.19 Collaborate and communicate with staff at the support units/departments for timely intervention in case of an emergency.
- 4.1.20 Communicate with the Neonatologist/Pediatrician for timely intervention in case of an emergency.
- 4.1.21 Ensure that he/she is readily available to manage any complication/s that may arise during labour and/or delivery.

4.2 Management of the client in 2nd stage of labour

Intent Statement: *This is the most hazardous stage of labour for the baby. Active pushing should not normally exceed sixty (60) minutes for primigravid clients and thirty (30) minutes for multigravid clients. The Obstetrician should be informed when there are concerns with the observations made.*

PROCEDURE

The Midwife shall:-

- 4.2.1 Ensure that the birthing area is prepared for the delivery of the newborn.
- 4.2.2 Ensure that the infant incubator or cot is prepared and positioned for receiving the newborn.
- 4.2.3 Advice and support the client on the position to be adopted for delivery.
- 4.2.4 Ensure that the required Protective Personal Equipment is worn in preparation for delivery.
- 4.2.5 Ensure that adequate privacy is provided during the birthing process.
- 4.2.6 Maintain communication with the client and guide her through the birthing process.
- 4.2.7 Announce to the staff the gender and time of birth of the newborn upon delivery.
- 4.2.8 Allow the mother to cuddle the newborn and confirm the gender immediately after birth.
- 4.2.9 Perform nasal and oral suctioning of the newborn following delivery as required.
- 4.2.10 Ensure that a Neonatologist/Pediatrician is present at all deliveries where the babies are at risk.
- 4.2.11 Administer intramuscular oxytocin to the client as per medication protocol.

- 4.2.12 Record the time and date of birth, gender of newborn and maternal name on the I.D. bracelet.
- 4.2.13 Attend to the newborn; allow the mother to confirm the information written on the identification bracelet and apply the I.D. bracelet onto the ankle or wrist of the newborn.
- 4.2.14 Conduct physical assessment on the newborn and assign an APGAR score.
- 4.2.15 Administer Vitamin K to the newborn as per medication protocol.
- 4.2.16 Perform cord care; the newborn is then clothed and wrapped to maintain body heat.
- 4.2.17 Transport the newborn to the mother in a cot and initiates breastfeeding unless otherwise indicated.

4.3 Pain Management in Labour

Intent Statement: *The meaning attached to pain also affects the degree and quality of pain expressed. Various methods can be used to assist the client to manage her pain in labour.*

The Midwife shall:-

- 4.3.1 Remind the client/patient of the techniques taught to her during her childbirth education.
- 4.3.2 Offer alternative techniques in labour which enhances comfort e.g. squatting, laboring in water.
- 4.3.3 Offer Entonox (50% Oxygen & 50% Nitrous Oxide) as per medication protocol.
- 4.3.4 Offer medication (e.g. Pethidine, Morphine) as per medication protocol.
- 4.3.5 Offer regional analgesic techniques as clinically indicated.
- 4.3.6 Ensure appropriate documentation in the client/patient's record.

4.4 Management of the client in 3rd stage of labour

Intent Statement: *Active Management of the third stage is recommended as there is evidence to prove that this type of management reduces the risk of Post Partum Haemorrhage. The Obstetrician should be informed if the 3rd stage is delayed for more than thirty (30) minutes.*

PROCEDURE:

The Midwife shall:-

- 4.4.1 Deliver the placenta and membranes.
- 4.4.2 Assess the perineum, vaginal floor and cervix for lacerations and then apply a sterile sanitary pad.
- 4.4.3 Assess the blood loss and uterine tone.
- 4.4.4 Ensure that the client is made comfortable in bed following delivery.
- 4.4.5 Ensure that the post delivery vital signs are monitored and recorded.
- 4.4.6 Examine the placenta and membranes for completeness, **record findings and report concerns.**
- 4.4.7 Obtain cord blood for laboratory analysis. (E.g. RH negative & O positive mothers)
- 4.4.8 Measure the blood loss.
- 4.4.9 Allow the client to rest for a minimum of 1 hr following delivery before transfer to the postnatal ward unless otherwise indicated.
- 4.4.10 Ensure that all care is documented in the client's health record.

4.5 MANAGEMENT OF COMPLICATIONS OF THE THIRD STAGE OF LABOUR

4.5.1 PROLONGED THIRD STAGE OF LABOUR

The Midwife shall:-

- 4.5.1.1 Attempt to deliver the placenta by continuous cord traction.
- 4.5.1.2 Inform the Obstetrician on duty if continuous cord traction fails.
- 4.5.1.3 Ensure that a urinary catheter is inserted and attached to a closed drainage system.
- 4.5.1.4 Obtain blood for Group & Cross Match.
- 4.5.1.5 Ensure an intravenous access and infusion is established.
- 4.5.1.6 Assess and record the vital signs of the client.
- 4.5.1.7 Alert the Operating theatre staff and Anesthetist.
- 4.5.1.8 Ensure client is informed of and understands the plan of care.
- 4.5.1.9 Administer prophylactic antibiotics as prescribed.

The Obstetrician shall:-

- 4.5.1.10 Assess client and confirm the plan of care
- 4.5.1.11 Prepare client for manual removal of placenta.
- 4.5.1.12 Inform client of the plan of care for removal of the placenta and obtain informed consent.
- 4.5.1.13 Inform immediate relatives/significant others of plan of care.
- 4.5.1.14 Prescribe prophylactic antibiotics

4.6 Management of the client in 4th stage of labour

PROCEDURE:

The Midwife shall:-

- 4.6.1 Ensure that the client's uterus is well contracted and assess the volume and nature of lochia.
- 4.6.2 Assess the coping ability of the client and provide the required support and comfort.
- 4.6.3 Prepare the client for perineal repair which shall be done within 1 hr following delivery.
- 4.6.4 Inform the Obstetrician and Paediatrician of any abnormalities.
- 4.6.5 Ensure that the client's vital signs are monitored and recorded.
- 4.6.6 Support the mother with bonding and breastfeeding during this period unless contraindicated.
- 4.6.7 Offer a light meal or refreshment as desired unless contraindicated.
- 4.6.8 Monitor and support the mother in the care of her newborn until transfer to the postnatal ward.
- 4.6.9 Make assessments of the client's lochia, fundal height and bladder function during the post partum period.
- 4.6.10 Administer to the baby born to an HIV positive client, a single dose of NVT 2mgm per kg body weight within six (6) hours after birth.
- 4.6.11 Document all findings in the client's health record.
- 4.6.12. Prepare client for transfer to postnatal ward.
- 4.6.13 Follow established infection prevention and control guidelines according to IPC manual.

5.0 INTRAPARTUM CARE (Abnormal Labour)

DEPARTMENT : Obstetric & Midwifery	EFFECTIVE DATE :
TOPIC : Management of the client with a singleton Breech Presentation in labour	REVIEW DATE :

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

Each Obstetric/Midwifery Unit will develop individual Guidelines for Management of the Breech delivery.

PROCEDURE

The Midwife shall:-

- 5.1 Conduct an abdominal examination and document findings in the client's health record.
- 5.2 Perform a sterile vaginal examination to (a) assess cervical dilation (b) confirm the presenting part and (c) exclude cord presentation/ prolapse.
- 5.3 Inform the on-call Obstetrician of the findings of the abdominal and vaginal examination.
- 5.4 Inform the Operating theatre, Anesthetist and Neonatologist/Pediatrician of the pending delivery.
- 5.5 Discuss the plan of care with the client to facilitate her active participation.
- 5.6 Employ pain management in accordance with written protocols and procedure.
- 5.7 Conduct continuous electronic fetal monitoring during the labour.

- 5.8 Collaborate with the Obstetrician to determine the appropriate mode of delivery after confirming the presentation.
- 5.9 Provide support and guidance to the client throughout the delivery process.
- 5.10 In the absence of the obstetrician, the midwife shall perform the breech delivery.
- 5.11 Ensure that the Obstetrician and Neonatologist/Pediatrician are present at a breech delivery.
- 5.12 Follow established infection prevention and control guidelines according to IPC manual.

The Obstetrician shall:-

- 5.13 Respond to the call from the Midwife in a timely manner
- 5.14 Perform the breech delivery if requested.

5.1 MANAGEMENT OF A CLIENT WITH A SHOULDER DYSTOCIA

DEPARTMENT : Obstetric & Midwifery	EFFECTIVE DATE :
TOPIC : Management of the client with a Shoulder Dystocia	REVIEW DATE :

Intent Statement: *Shoulder Dystocia is the impaction of the fetal shoulders against the pubis (check definition from NICE GUIDELINES). It is a delivery that requires additional maneuvers to deliver the shoulders. If not dealt with expeditiously fetal death can occur. The obstetrician must be informed as soon as the problem is recognized.*

PROCEDURE

The Midwife shall:-

- 5.1.1 Recognize the problem and call for assistance.
- 5.1.2 Call Registrar/Consultant, theatre anesthetist and pediatrician.
- 5.1.3 Note the time of delivery of the head.
- 5.1.4 Explain the procedure to the client to gain her cooperation.
- 5.1.5 Avoid fundal pressure and extensive traction on the fetal neck.
- 5.1.6 Perform an episiotomy if possible.
- 5.1.7 Conduct the **Mc Roberts maneuver**.
- 5.1.8 Apply suprapubic pressure over the fetal anterior shoulder.
- 5.1.9 Attempt to deliver the posterior shoulder.
- 5.1.10 Ensure the pediatrician is present for the delivery as well as ensuring that resuscitative equipment is present and functional.
- 5.1.11 Follow established infection prevention and control guidelines according to IPC manual.

Following delivery

Note time of delivery of baby

- Time of call for assistance
- Baby's condition
- Names of staff present
- Complete incident form
- Affix signature

The Obstetrician shall-:

- 5.1.12 Explain the procedure to the client including the inherent risks and obtain informed consent.
- 5.1.13 Attempt different maneuvers to deliver the baby as in 5.1.7.-5.1.9 and if all else fails then **Zavannelli maneuver** should be considered.
- 5.1.14 Alert Operating theatre staff and anesthetist, client/patient to be transferred to the OT if all attempts fail.
- 5.1.15 Complete the Shoulder Dystocia form.
- 5.1.16 Follow established infection prevention and control guidelines according to IPC manual.

6.0 MANAGEMENT OF INSTRUMENTAL DELIVERIES

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Management of Instrumental Deliveries

REVIEW DATE :

Intent Statement: Instrumental deliveries: forceps or ventouse is employed to assist the delivery of the fetus for maternal and fetal indications.

6.1 FORCEPS DELIVERY

PROCEDURE

The Obstetrician shall:-

- 6.1.1. Determine the indication for a forceps delivery.
- 6.1.2. Communicate with the client/patient on the need for a forceps delivery.
- 6.1.3. Ensure that the pediatrician is present during the delivery.
- 6.1.4. Explain the procedure to the client/patient including the inherent risks and obtain informed consent.
- 6.1.5. Apply the appropriate technique in conducting the delivery in keeping with established guidelines.
- 6.1.6. Examine for any traumatic lacerations to the maternal genital tract and rectum/anal sphincter and perform timely repair.
- 6.1.7. Document all information related to the procedure.
- 6.1.8. Follow established infection prevention and control guidelines according to the MoH Infection, Prevention and Control Manual.

6.2 VENTOUSE EXTRACTION

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

The Obstetrician shall:-

- 6.2.1 Inform the Neonatologist/Pediatrician and alert the Operating Theatre staff.
- 6.2.2 Ensure that the period of gestation is greater than 34 weeks.
- 6.2.3 Choose the appropriate size cup that will fit the baby's head.
- 6.2.4 Ensure that no cervix or the vaginal wall is trapped beneath the rim of the cup.
- 6.2.5 Establish gentle suction while the client continues to push during contractions.
- 6.2.6 Perform episiotomy during the crowning of the head.
- 6.2.7 Release suction and remove cup once the head is delivered and complete delivery as normal.
- 6.2.8 Follow established infection prevention and control guidelines according to IPC manual.

The Midwife shall:-

- 6.2.9 Prepare the client/patient and the environment of care for the conduct of the delivery.
- 6.2.10 Provide support and counseling for the client and family throughout the delivery.
- 6.2.11 Assist the Obstetrician in the conduct of the delivery.
- 6.2.12 Assist the Neonatologist/Pediatrician in the resuscitation of the newborn and ensure that the APGAR score is recorded.
- 6.2.13 Ensure that all care is documented accurately and in a timely manner.
- 6.2.14 Ensure that assessment of vital signs are made and recorded in the client's Health Record.

6.2.15 Monitor and record

- The client's vital signs
- Lochia
- Coping patterns

6.2.16 Accompany the newborn to the Neonatal Unit if admission is required following assessment and resuscitation by the Pediatrician.

6.2.17 Provide emotional support for the mother and immediate family members.

6.2.18 Follow established Infection, Prevention and Control Guidelines according to the MoH Infection, Prevention and Control Manual.

6.2.19 Ensure that the Neonatologist/Pediatrician is present at all instrumental deliveries.

6.2.20 Ensure that all available resuscitative equipment and supplies are functional.

The Pediatrician shall:-

6.2.21 Be present at all instrumental deliveries.

7.0 CAESAREAN SECTION

DEPARTMENT : Obstetric & Midwifery	EFFECTIVE DATE :
TOPIC : Management of a client having a Caesarean Section	REVIEW DATE :

Intent Statement: *A Caesarean Section is the abdominal delivery of the fetus after the twenty-eighth week of pregnancy. The procedure could be emergency, urgent, scheduled or elective.*

A Consultant or a Registrar should plan and be in attendance when a Caesarean Section is being performed for any high risk pregnancy.

PROCEDURE

The Obstetrician shall:-

- 7.1 Inform the client and immediate relatives of the indication for Caesarean section.
- 7.2 Communicate with the Anaesthetist and theatre staff on the need for surgical intervention.
- 7.3 In the absence of an indication for General anesthesia, recommend spinal or regional anesthesia.
- 7.4. Plan and perform the appropriate surgical incisions and techniques in order to facilitate a safe delivery of the fetus and to ensure maternal well being.
- 7.5. Administer prophylactic antibiotics after delivery of the fetus unless previously administered for clinical indication.
- 7.6 Ensure that the Anesthetist administers an oxytocic agent after delivery of the fetus.
- 7.7 Ensure that there is adequate uterine repair and surgical haemostasis before the abdomen is closed.

- 7.8 Collaborate with the surgical team on the determination of the volume of blood loss and the timely replacement of same which may include a combination of crystalloids, colloids and blood products.
- 7.9 Explain the procedure to the client including the risks involved.
- 7.10 Obtain signed consent from the client, next of kin or legal representative.
- 7.11 Communicate with the Laboratory Technician for the preparation of blood for transfusion if indicated.
- 7.12 Plan delivery in collaboration with the Neonatologist/Pediatrician.
- 7.13 Ensure that the client is closely monitored in the immediate postoperative period before transfer to the postnatal ward.

The Midwife shall:-

- 7.14 Conduct a full physical assessment including abdominal palpation on the client/patient.
- 7.15 Ensure that client is informed of the indication for the surgery.
- 7.16 Ensure that informed consent is obtained from the client or legal representative.
- 7.17 Inform the neonatal unit of the pending C/Section.
- 7.18 Monitor and record client/patient's vital signs.
- 7.19 Monitor and record fetal heart rate, rhythm and well being.
- 7.20 Ensure that client is emotionally and physically prepared.
- 7.21 Ensure that the abdomen and pubic areas are shaved unless otherwise contraindicated.
- 7.22 Ensure that blood samples are sent to the laboratory for analysis.
- 7.23 Ensure that a urinary catheter is inserted just prior to surgery and attached to a closed drainage system.

- 7.24 Ensure that all care delivered is accurately documented in the client/patient's health record.
- 7.25 Apply the Surgical Safety Checklist and document results.
- 7.26 Inform the client's designated relative of the plan of care and the indication for Caesarean Section.
- 7.27 Accompany the client to the operating theatre.
- 7.28 Encourage bonding and breast feeding initiation in keeping with the Baby Friendly initiative if not contraindicated.
- 7.29 Transfer baby to the Neonatal Unit/Nursery as indicated.

7.1 Care of the client following a Caesarean Section Delivery

The Midwife shall:-

- 7.1.1 Ensure that a plan of care is documented in the health care record.
- 7.1.2 Ensure that the client is placed in a comfortable position in bed.
- 7.1.3 Monitor the vital signs every fifteen (15) minutes for the first hour then every half (1/2) hour for the next two (2) hours then four (4) hourly as necessary. If abnormal readings are noted, perform a verification check and inform the Obstetrician immediately.
- 7.1.4 Check the following
 - IV line is established
 - Dressings intact with no sign of bleeding
 - Urethral catheter is draining freely
 - Uterine tone

- Lochia is normal
- General appearance of the client

7.1.5 Administer pain medication as prescribed.

7.1.6 Assist with bonding and breast feeding unless contraindicated.

7.1.7 Remove urethral catheter as prescribed twenty – four (24) hours post surgery unless otherwise indicated.

7.1.8 Discontinue IV therapy as prescribed twenty – four (24) hours post surgery unless otherwise indicated.

7.1.9 Monitor urinary output.

7.1.10 Ambulate client according to plan, providing assistance as necessary.

7.1.11 Apply Infection, Prevention and Control principles according to the MoH IPC Manual.

8.0 MANAGEMENT OF THE CLIENT / PATIENT WITH MULTIPLE PREGNANCIES

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Management of the patient with multiple pregnancies

REVIEW DATE :

Intent Statement: *Multiple pregnancies and labour can involve either twin, triplets or as much as sextuplets. This type of pregnancy carries with it certain kinds of risk; once diagnosed the aim of the intra-partum care should be to ensure a safe delivery and a favourable outcome for both client and neonates.*

The Midwife shall:-

- 8.1 Conduct a full physical assessment including abdominal palpation.
- 8.2 Determine the presence of a multiple pregnancy.
- 8.3 Ensure that the client is aware that she is carrying more than one (1) fetus.
- 8.4 Determine if possible that heart beat of the two fetuses are present.
- 8.5 Determine if possible the lie, position and presentation of the fetuses.
- 8.6 Assess, monitor and record the rate, frequency and consistency of uterine contractions experienced by the client.
- 8.7 Obtain if possible Cardiotocography (CTG) recordings of the fetal heart rate patterns.
- 8.8 Inform the Obstetrician of the findings condition of the client.
- 8.9 Employ pain management techniques in accordance with established pain management protocols and guidelines.
- 8.10 Prepare the client for delivery if labour is established and progressing normally.

The Obstetrician shall-:

- 8.11 Determine the mode of delivery.
- 8.12 Communicate to the client and immediate relative the mode of delivery and the reason for that choice of delivery.
- 8.13 Ensure the presence of a Pediatrician/Neonatologist at the delivery.

9.0 POST - NATAL CARE

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Post – natal Care

REVIEW DATE :

Intent Statement: *The postnatal period marks the beginning of the parent-child relationship and provides an opportunity for adjustment of the family to the newborn. Healthcare providers play an important role in maintaining the health and welfare of mother and child by the promotion of family life education.*

The Midwife shall:-

- 9.1 Assess all clients before transfer to a postnatal ward and/or primary care facility. The assessment shall include: vital signs, urinalysis, and examination of the:-
 - Perineum
 - Vaginal floor
 - Abdominal palpation
 - Uterine tone
 - Bladder and bowel function
 - Lochia
 - Breast
 - Coping ability with newborn
- 9.2 Assess the mother's level of adaptation with breastfeeding and caring for her newborn.
- 9.3 Teach the client and support her in the technique of breast feeding unless contraindicated.
- 9.4 Teach the client the appropriate perineal hygiene.
- 9.5 Teach the client to observe the cord for bleeding and signs of infection.
- 9.6 Provide information to the mother before discharge on signs of complications in both mother and baby.

- 9.7 Inform the mother of the schedule for postnatal visits and available Family Planning services.
- 9.8 Inform the mother of the procedure for registration of the birth.
- 9.9 Advise and guide the client/patient on the practice of pelvic floor exercises.
- 9.10 Document accurately all care delivered shall be in the client's health records.
- 9.11 Conduct a head to toe assessment on the newborn immediately following birth in accordance with clinical practice guidelines.
- 9.12 Ensure that all neonates are examined by a Paediatrician within 24hrs following birth.
- 9.13 Observe closely (q4h) for 24hrs, all neonates who were born through meconium stained liquor and inform the Pediatrician/Neonatologist of any changes.
- 9.14 Ensure that all neonates are fitted with an I.D. band at the time of birth.
- 9.15 Ensure that all neonates are assessed for normal bowel and bladder function before discharge.
- 9.16 Assess the feeding and sleeping pattern of all neonates before discharge.
- 9.17 Perform pre and post blood glucose level on all babies born to diabetic mothers.
- 9.18 Ensure a RH negative factor mother with an RH positive baby is given Rhogram IM before discharge.
- 9.19 **Ensure the neonate of a HIV client is given a bath soon after birth.**
- 9.20 **Ensure that the HIV positive mother is given the schedule for the baby to receive AZT 4mgm per kg body weight for up to 4weeks after birth.**
- 9.21 Assess the neonate for signs of jaundice during the infant's stay at the unit.
- 9.22 Document all care delivered and report all abnormal findings to the Pediatrician.

9.23 Teach the client on the following:-

- Perineal care
- Diet
- Breastfeeding
- Bonding
- Family planning
- Physical activity

10.0 MANAGEMENT OF THE CLIENT WITH OBSTETRIC EMERGENCIES

DEPARTMENT : Obstetric & Midwifery	EFFECTIVE DATE :
TOPIC : Management of the client with Obstetric Emergencies	REVIEW DATE :

Intent Statement: *Obstetric emergencies include pre-eclampsia, eclampsia, ante-partum haemorrhage, premature rupture of membranes, prolapsed cord, post partum haemorrhage (PPH) maternal collapse and fetal distress. These are very serious conditions in pregnancy; if they are not addressed in a timely manner, can lead to a life threatening situation for mother, fetus or in some severe situations both would be at risk.*

10.1 MANAGEMENT OF THE CLIENT WITH PRE-ECLAMPSIA

PROCEDURE

The Midwife shall:-

- 10.1.1 Obtain a complete history for the client/patient.
- 10.1.2 Manage the care of the client/patient utilizing the nursing process.
- 10.1.3 Test urine daily for proteinuria.
- 10.1.4 Collect 24 hour urine specimen for total protein.
- 10.1.5 Measure client's blood pressure as prescribed; noting any changes in blood pressure.
- 10.1.6 Measure the client's weight daily.
- 10.1.7 Administer prescribed medications.
- 10.1.8 Observe the client for signs and symptoms of impending eclampsia which include -
 - Severe frontal headache
 - Visual disturbance
 - Vomiting
 - Epigastric pain
 - Oliguria
 - Oedema

- 10.1.9 Obtain Cardiotocography (CTG) or Electronic Fetal Monitoring recordings to assess the status of the fetus
- 10.1.10 The attending midwife shall inform the Obstetrician of the signs and symptoms of the imminent eclampsia.
- 10.1.11 Nurse the client in a bed with side rails and in a quiet environment.
- 10.1.12 Continue to observe the client closely for early signs of eclampsia.
- 10.1.13 Refer the client/patient to the Nutritionist for the appropriate meal plan.
- 10.1.14 Educate the client/patient on her condition and allay any fears.
- 10.1.15 Document all care delivered on the prescribed forms in a timely manner.

The Obstetrician shall:-

- 10.1.16 Prescribe sedation and anti-hypertensive drugs as required.
- 10.1.17 Document a plan of care for the client/patient based upon the signs and symptoms experienced by the client.
- 10.1.18 Monitor the reflexes of the client.
- 10.1.19 Conduct the necessary laboratory tests and monitor results.

10.2 MANAGEMENT OF THE CLIENT/PATIENT WITH ECLAMPSIA

Intent Statement: This condition is life threatening and there are critical steps which must be undertaken to maintain a clear airway and to protect the mother from injury.

The Midwife shall:-

- 10.2.1 Manage the client/patient utilizing the nursing process.
- 10.2.2 Ensure that a clear airway is maintained.
- 10.2.3 Ensure that client is nursed within a bed with side rails up and in a quiet environment.

- 10.2.4 Ensure that emergency equipment is available and functional.
- 10.2.5 Establish IV access.
- 10.2.6 Observe and record the fetal heart.
- 10.2.7 Inform the Obstetrician immediately of any change in client's condition or the fetal condition.
- 10.2.8 Maintain a strict fluid intake & output chart.
- 10.2.9 Administer medication as prescribed.

The Obstetrician shall:-

- 10.2.10 Prescribe anticonvulsive drugs as required.
- 10.2.11 Prescribe antihypertensive drugs as required.
- 10.2.12 Obtain blood specimens for laboratory analysis.
- 10.2.13 Establish an I.V. access if none has been established.
- 10.2.14 Document a plan of care for the client based upon the signs and symptoms experienced by the client.
- 10.2.15 Inform the theatre staff and Pediatrician of the possible caesarean section.

10.3 MANAGEMENT OF THE CLIENT WITH ANTEPARTUM HAEMORRHAGE

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

PROCEDURE

The Midwife shall:-

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

The Obstetrician shall:-

- 10.3.14 Explain to the client and significant other the nature and risks involved in the existing situation.
- 10.3.15 Utilize the relevant technology that will assist in the confirmation of diagnosis and treatment.
- 10.3.16 Administer the appropriate intravenous fluids if blood loss is severe.

- 10.3.17 Obtain the relevant blood samples for testing to assist in the diagnosis and treatment.
- 10.3.18 Obtain an informed consent from the client in the event there is need to perform an emergency Caesarean Section.
- 10.3.19 Evaluate the client's progress and revise the plan of care as necessary.

10.4. PREMATURE RUPTURE OF MEMBRANES

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

PROCEDURE

The Midwife shall:-

- 10.4.1 Manage the care of the client utilizing the nursing process.
- 10.4.2 Take a complete history from the client, noting the date and time of rupture.
- 10.4.3 Explain to the client and significant other the nature and risks involved in the existing situation and attempt to allay fears.
- 10.4.4 Conduct a complete abdominal examination of the client.
- 10.4.5 Assess the volume, colour, odour and consistency of the liquor.
- 10.4.6 Prepare the client for a speculum vaginal examination.
- 10.4.7 Monitor vital signs as often as required noting temperature variations.
- 10.4.8 Monitor fetal heart rate every two (2) hours or as prescribed by the Obstetrician.
- 10.4.9 Ensure the client maintains a "kick" count chart.
- 10.4.10 Utilize the relevant technology to assist with monitoring the fetal heart rate.
- 10.4.11 Maintain bed rest with the foot of the bed elevated until client is reviewed by the Obstetrician.

The Obstetrician shall:-

- 10.4.12 Utilize the relevant technology to assist in diagnosis and treatment of the client
- 10.4.13 Obtain the relevant blood samples for testing to assist in the diagnosis and treatment.
- 10.4.14. Develop a detailed plan of care for the client.
- 10.4.15 Inform client/patient or significant other of the plan of care and obtain consent where applicable.
- 10.4.16 Prescribe the appropriate antibiotic where appropriate.
- 10.4.17 Evaluate the client's progress and revise the plan of care is necessary.

10.5 CARE OF THE CLIENT WITH A CORD PROLAPSE

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

PROCEDURE

The Midwife shall:-

- 10.5.1 Manage the care of the client utilizing the nursing process.
- 10.5.2 Assist and support the client in position (exaggerated Sims) to prevent cord compression.
- 10.5.3 Provide the client with the necessary support and information to gain her cooperation.
- 10.5.4 Conduct a vaginal examination to determine (a) the degree of cervical dilatation, (b) the presenting part and (c) cord pulsation.
- 10.5.5 Apply sterile gauze moistened with warm saline on cord if appropriate.

- 10.5.6 Establish an IV access and keep client/patient nil per oral route (NPO).
- 10.5.7 Monitor and record the health status of the fetus using the appropriate technology.
- 10.5.8 Inform the Obstetrician, giving details of the obstetric history and present findings.
- 10.5.9 If there is no cord pulsation, and no fetal heart is heard, spontaneous vaginal delivery is allowed.
- 10.5.10 If cord pulsation is felt and fetal heart is heard, prepare client for delivery via Caesarean Section or vaginal delivery as appropriate.
- 10.5.11 In the event of fetal demise, provide emotional support to the client and significant other and refer for bereavement counseling and monitor/follow up.

The Obstetrician shall:-

- 10.5.12 Determine fetal viability using appropriate technology.
- 10.5.13 Utilize the relevant technology to assist in diagnosis and treatment of the client.
- 10.5.14 Obtain the relevant blood samples for testing to assist in treatment.
- 10.5.15 Document a plan of care for the management of the client.
- 10.5.16 Inform the theatre staff and Pediatrician of possible Caesarian Section.
- 10.5.17 Inform the client and significant other of the plan of care.

10.6 POST PARTUM HAEMORRHAGE

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

PROCEDURE

10.6.1 Minor Post Partum Hemorrhage

The Midwife shall:-

- 10.6.1.1 Inform the Midwife in charge of the shift.
- 10.6.1.2 Inform the obstetrician on duty of assessment of findings.

10.6.2 Major Post Partum Hemorrhage

The Midwife shall:-

- 10.6.2.1 Inform the Midwife in charge of the shift.
- 10.6.2.2 Inform the Obstetric House Officer and Registrar.
- 10.6.2.3 Inform the Consultant and the Anesthetist.
- 10.6.2.4 Obtain blood for CBC, clotting screen, Group & Cross Match, RFT, LFT.
- 10.6.2.5 Ensure an intravenous access and infusion is established.
- 10.6.2.6 Place client/patient in a supine position and maintain warmth.
- 10.6.2.7 Examine the placenta for completeness.
- 10.6.2.8 Examine the abdomen to establish uterus is contracted.
- 10.6.2.9 Stimulate the abdomen to ensure contraction of the uterus.
- 10.6.2.10 Administer Oxytocic agents e.g. Syntocinon, Carbetocin, Misoprostol as prescribed.
- 10.6.2.11 Ensure that a urinary catheter is inserted and attached to a closed drainage system.
- 10.6.2.12 Measure and record the blood loss.
- 10.6.2.13 Assess and record the vital signs of the client/patient.
- 10.6.2.14 Make client/patient comfortable and allay her fears.

The Obstetrician shall:-

- 10.6.2.15 Determine the cause of the hemorrhage – uterine atony, trauma to the tissues, retained placenta or products, DIC.
- 10.6.2.16 Communicate with the client and or relatives.
- 10.6.2.17 Obtain informed consent for emergency procedure under GA (if necessary).
- 10.6.2.18 Obtain a history from the attending staff.
- 10.6.2.19 Ensure airway is patent, breathing is maintained.

10.6.2.20 Ensure oxytocic agents were administered.

10.6.2.21 Commence blood transfusion (unless there are religious objections).

10.6.2.22 Consult with a second senior clinician, if hysterectomy is to be considered.

11.0 MATERNAL COLLAPSE

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Management of Maternal Collapse in pregnancy and the puerperium

REVIEW DATE :

Intent Statement: *Maternal collapse is defined as an acute event involving the cardio-respiratory systems and or brain, resulting in a reduced or absent conscious level (and potential death) at any stage in the pregnancy and up to six weeks after delivery. Maternal collapse could occur with no prior warning although there are existing risk factors which can precipitate such a collapse. Haemorrhage is the most common cause of maternal collapse. It is recommended that an obstetric early warning score chart should be used routinely for all client/clients to allow for early recognition of the client/client who is becoming critically ill.*

PROCEDURE

The Obstetric/ Midwifery Unit shall:-

- 11.1 Have an established procedure for management of all Obstetric emergencies.
- 11.2 Ensure that there is an appropriate complement of functional resuscitative equipment.
- 11.3 Ensure that the resuscitation trolley has an adequate supply of drugs and these are checked daily for expired drugs as well as to be replenished after use.
- 11.4 Have a system of alerting all relevant staff in the event of an emergency including senior Obstetrician, Anesthetist, Midwife, Laboratory and Ancillary personnel.
- 11.5 Ensure that a programme is in place for all relevant staff to receive updated and continuous training in the management of Obstetric emergencies.

The Midwife shall:-

- 11.6 Call for help immediately, if client/patient collapses and commence resuscitative process using the appropriate algorithm.

- 11.7 Identify and assign team functions.
- 11.8 Monitor and record vital signs.
- 11.9 Inform the Neonatologist/Pediatrician if appropriate.
- 11.10 Ensure that the relatives are informed of the changes in the client/patient's condition.

The Obstetrician shall :-

- 11.11 Assess the client/patient's condition and determine the plan of care.
- 11.12 Ensure airway is patent and lung fields are clear.
- 11.13 Continue resuscitation process using the approved algorithm.
- 11.14 Ensure IV therapy is controlled to prevent fluid overload.
- 11.15 Draw blood for relevant blood investigations as per algorithm.
- 11.16 Perform an Abdominal Ultra Sound to aid in diagnosis of abdominal haemorrhage, if indicated.
- 11.17 Communicate with Pediatrician if collapse occurs during the antenatal care.
- 11.18 Make a determination for a surgical intervention if there is little or no response after five minutes.
- 11.19 Communicate with the significant other or relatives, the present situation with the client/patient.

12.0 MANAGEMENT OF THE CLIENT WITH AN “AT RISK” PREGNANCY

DEPARTMENT : Obstetric & Midwifery	EFFECTIVE DATE :
TOPIC : Management of the patient with an “At Risk” pregnancy	REVIEW DATE :

Intent Statement: *An “At risk” or High Risk Pregnancy is a pregnancy which can create challenges for a satisfactory outcome for the client with an underlying. Medical condition or a client who is at risk for developing complications of pregnancy.*

A high risk pregnancy is one in which the client

- *Has Diabetes Mellitus*
- *Has hypertension*
- *Is a Teenage Pregnant Client*
- *Is a Grand Multigravida Client*
- *Has a Cardiac or Renal condition*
- *Is obese*

Any client categorized as a high risk pregnancy is given a referral to the hospital ANC by the end of the first trimester.

The Midwife shall ensure that-:

- 12.1 The client is assessed by an obstetrician on the first visit.
- 12.2 The client is given a referral to the hospital ANC by the end of the first trimester.
- 12.3 The client specific condition is monitored at every visit.
- 12.4 The diabetic client has her blood sugar tested on each visit.
- 12.5 The client with a hypertension in pregnancy is examined for signs of pre-eclampsia at every visit to the ANC.
- 12.6 The client with moderate to severe hypertension should be assessed for renal function, once in every trimester.

- 12.7 The client and significant other are educated at every visit on the diet and the signs & symptoms of impending complications.
- 12.8 Develop an agreed plan of care for the client.

The Obstetrician shall:-

- 12.9 Conduct a complete assessment of the client with an “at risk” pregnancy on her first visit to the ANC.
- 12.10 Utilize the health technology to assist in the treatment of the client and fetus.
- 12.11 Obtain the relevant blood samples for testing.
- 12.12 Assess the health status of the fetus at every visit from 20 week up to the delivery.
- 12.13 Explain the plan of care to the client and provide updates on the plan of care as appropriate.
- 12.14 Prescribe the appropriate medication for the client as necessary.
- 12.15 Ensure appropriate coverage is provided for the management of the client during labour and delivery.
- 12.16 Ensure timely communication and collaboration among support staff e.g. Pediatrician/Neonatologist, Social Worker, Medical Unit, Hematologist etc.
- 12.17 Ensure referral is provided for follow up care at the relevant Primary Health Care Facility or Practitioner after delivery.

13.0 BEREAVEMENT

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Management of the client and family following an IUD or death of a newborn

REVIEW DATE :

SUPPORT FOR THE FAMILY WHO HAS EXPERIENCED THE DEATH OF THE BABY

Intent Statement: Stillbirths and neonatal deaths are very devastating for parents; especially when they can see no reason for the baby's death. It is very important that the professional staff be trained to support not only the mother, but the entire family who has lost a new addition to the family.

PROCEDURE

The Obstetrician shall:-

- 13.1 Confirm the time of death.
- 13.2 Order the removal of all equipment used during resuscitation.
- 13.3 Communicate with the parents, indicating the death of the baby.
- 13.4 Advise parents if there is need for a post mortem and obtain consent.
- 13.5 Refer the parent and relatives for counseling.
- 13.6 Document the relevant information in the client/patient's health record.
- 13.7 Ensure the relevant forms are signed for disposal.

The Midwife shall:-

- 13.8 Provide necessary emotional support for the client/patient and family.
- 13.9 Ensure the client/patient and family has privacy.
- 13.10 Allow the client/patient and significant other, time to hold the baby if she so desires.
- 13.11 Arrange for photographs to be taken and other mementos which they may want to keep.
- 13.12 Offer to contact other family members or close friends.
- 13.13 Contact the hospital chaplain or other religious leader, if the parents so wish.

- 13.14 Ensure that the family meets with the counselor or social worker before discharge.
- 13.15 Advise the client/patient and significant other to register the death.
- 13.16 Ensure the relevant forms are signed for disposal.

* In the event of an Adverse Event, the Accident & Emergency Policy & Guidelines for the facility shall be followed.

Appendix I

14.0 PATIENT HANDOVER

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Patient Handover

REVIEW DATE :

Intent statement: *The handover procedure between shifts and between teams is a necessary and vital part of the Obstetric/Midwifery practice in order to minimize the risk of medical errors. It is important to communicate critical information as an essential component of Risk Management and Client Safety. (Royal College of Gynecologists 2010.)*

PROCEDURE

The Obstetrician shall:-

- 14.1 Conduct case reviews with the Obstetric staff weekly or monthly.
- 14.2 Ensure that daily ward rounds are conducted to plan and review client care.
- 14.3 Ensure that the junior officers are supervised at all times while on duty.
- 14.4 Respond in a timely manner to all requests from the midwifery staff.

The Midwife Shall:-

- 14.5 Develop a care plan for each client admitted to the Obstetric/Midwifery Unit.
- 14.6 Participate in the handover of each client on every shift.
- 14.7 Conduct a midwifery round following the handover at each shift.
- 14.8 Conduct ward rounds with the obstetrician to plan and review client care.
- 14.9. Ensure the implementation of approved SOPs, Policies and Guidelines relative to midwifery care.

The information communicated should include-:

- **Situation:** Describing the specific situation about the client, including name, consultant, client location, vital signs, resuscitation status and any specific concerns.
- **Background:** Including date of admission, diagnosis, current medications, allergies, laboratory results, progress during the admission and other relevant information collected from the client's charts.
- **Assessment:** Critical evaluation of the situation, clinical impressions and detailed expression of concerns.
- **Recommendation:** This involves the management plan, making suggestions and being specific about requests and time frame. Orders given, especially orders given over the telephone; or repeat discussions which may not be very clear.

Appendix II

THE PARTOGRAM

DEPARTMENT : Obstetric & Midwifery

EFFECTIVE DATE :

TOPIC : Patient Handover

REVIEW DATE :

Intent Statement: *The Partogram is a graphic representation of the progress of labour. It depicts the progress of labour at a glance and allows for failure to progress to be readily recognised. The pictogram should be used for all clients admitted in established labour. It is a record of care which constitutes a legal document, and is also an avenue for identifying accountability in midwifery practice.*

PROCEDURE

ADMISSION & ASSESSMENT

1. The client's identification label should be placed in the top left hand corner of the document.
2. Admission details should be recorded as soon as practicable following arrival
3. The entries should include
 - Date
 - Gravidity
 - Parity
 - EDD
 - Gestation
 - Date & Time of commencement of labour
 - Date & Time & mode of ruptured membranes
 - Age, blood group, weight, any relevant, Obstetric and Medical history, risk factors, allergies.

DATE

Record the commencement date at the top of the partogram. The date changes at midnight. The new date is then entered.

TIME

Note the exact time of the first observation that you wish to record.
Fill in the time scale along the top of the partogram.

MATERNAL ASSESSMENT

Record the maternal blood pressure, temperature, respirations or any other observations on the graph at the top of the partogram.

FETAL HEART RATE

During the 1st stage, the fetal heart rate is recorded every half hour.

During the 2nd stage of labour, the FHR is recorded every 5 minutes if the fetus is not continuously monitored.

LABOUR ASSESSMENT

Contractions are recorded graphically below the fetal assessment; other recordings – Abdominal palpation, cervical dilatation, descent of the head, vaginal examinations, Oxytocin administration, fluid balance, intrapartum medications, blood loss.

APPENDIX II (B)

Time (Hours)

MINISTRY OF HEALTH
PARTOGRAM

Name: _____

Reg. No. _____

	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16
Oxytoxin Drops / on Mlu/mil																	
Drugs & IV Fluids																	
Strong Mod. Mild Irreg. Freq. Duration																	
Blood Pressure																	
Pulse Rate																	
Temperature (0c)																	
Protein																	
Acetone																	
Glucose																	
Volume (mis)																	
Examine By:																	

Time (Hours)

GLOSSARY OF TERMS

- APGAR Score - The assessment of the baby's condition one (1) minute after birth by observing the colour, respiratory effort, heart rate, muscle tone and response to stimuli.
- Ante-natal - The period of pregnancy up to the commencement of established labour.
- Breech Presentation - A presentation in which the fetal buttocks with or without feet, lie lowermost in the maternal uterus.
- Bonding - The physical and emotional attachment formed between mother and baby after birth
- Caesarean Section - Delivery of the fetus by surgical intervention
- Cephalo Pelvic - The disproportionate measurement between the head of the fetus and the pelvis of the mother.
- Cervical ripening - The softening, effacement of the cervix favouring, the induction of labour.
- Consultant - Specialist Medical Officer
- Coping Ability - The client's ability to endure the rate the uterine contractions as the labour progresses.
- Engagement - The transverse diameter of the head passes through the brim of the pelvis.
- Fetal Maturity - The gestational age of the fetus during the pregnancy
- Intra Natal - The period of labour up to the birth of the baby

- Labour - Uterine contractions, increasing in intensity and frequency leading to the expulsion of the fetus, placenta and membranes after twenty - eight (28) weeks.
- Lochia - Discharges from the uterus occurring after child birth and persisting for three – four (3-4) weeks after delivery.
- Mc Roberts Maneuver - A maneuver to rotate the angle of the Symphysis Pubis superiorly and release the impact of the anterior shoulder in shoulder dystocia.
- Obstetric Partogram - Chart used for recording the progress of labour including frequency and intensity of contractions and the fetal heart rate
- Post Natal - Period of not less than six (6) weeks after delivery of the baby.
- Senior Midwife - Registered Nurse Midwife
- Zavanelli Maneuver - Last choice maneuver to relieve shoulder dystocia. (Head is returned to pre recitative position, then flexed back into the vagina)

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