# Maternity Record Book

## A Practical Record Book of Obstetrics

***As per the revised INC syllabus***

**Name of the Candidate:** _____

**Name of the Institution:** _____

_____

**Smriti Mani**

4th Edition

JAYPEE

# Contents


| | | |
|---|---|---|
| 1. | Antenatal Assessment and Care Records | 1 |
| 2. | Observation of Normal Childbirth and Assisting in Abnormal Deliveries | 131 |
| 3. | Per Vaginal Examination | 149 |
| 4. | Intranatal Assessment using Partograph, Assisting and Conduction of Normal Deliveries | 173 |
| 5. | Episiotomies and Suturing (Only if Indicated) | 343 |
| 6. | Newborn Resuscitation | 351 |
| 7. | Placenta Examination | 365 |
| 8. | Postnatal Assessment and Care | 373 |
| 9. | Newborn Assesment | 473 |
| 10. | Kangaroo Mother Care (KMC) | 497 |
| 11. | Counseling Mother and Family Member | 511 |
| 12. | Intrauterine Device Insertion Including PPIUCD Insertion | 517 |
| 13. | Nursing Care Plan/Case Presentation with Drug Study | 537 |

CHAPTER

4

# Intranatal Assessment using Partograph, Assisting and Conduction of Normal Deliveries



## ARTICLES REQUIRED FOR NORMAL DELIVERY

**A. Nurses preparation**

A tray containing:

- Handwashing articles.
- Plastic apron.
- Gown.
- Mask.

**B. Patient preparation**

A tray containing:

- Gown
- Leggings.

**C. Unit preparation**

- Screen
- Light
- Bed
- Bucket
- Kelly's pad.
- A big container with 0.5% bleaching solution.
- A tray containing—0.2% injection lignocaine, spirit, cotton balls, knife dish, syringes, IV sets, fluid bottles, venflons, leucoplasts/micropore.
- A drug tray containing syntocinon, methergin, prostodin, pethidine, calmpose, etc.
- Baby resuscitation articles.

**D. A sterile tray containing**

Two pairs of gloves, cotton swabs with antiseptic solutions for cleaning of vulva, gauze pieces, episiotomy scissors, plain scissors, Kocher's forceps, artery forceps, eye swabs, sterile vaginal pads, syringes with needles, speculum, catheter, cord ligature/cord clamp, draping sheet.

**E. Baby receiving articles**

Two pre-warmed towel, cord clamp, disk number, mucous sucker with catheter.

## PLACENTAL EXAMINATION TRAY

**A. A tray containing:** Clean gloves, pins, cotton swabs, thread, tape measure, kidney dish with lining, yellow plastic bag, Mackintosh, a bowl of water.

**B. Placenta in a bowl**.

**C. Weighing machine**.

**D. An examination tray with lining**.

**E. 0.5% bleaching solution**.

# CONDUCTION OF NORMAL DELIVERY

## EXAMPLE

### CASE NO. 1

#### Identification Data

Name of the hospital: CRSS Hospital Registration No. 1554

Name of the client: Mrs Rinku Manna Age: 21 years

Address with husband's name: W/o Dibyendu Manna, 393, Beltala road, Kolkata 20, PS: Bhawanipur

Religion: Hinduism GPLA: G1P0L0A0 Period of gestation: Full- term

LMP: 20.05.01 EDD: 27.02.02 Date and time of admission: 13.02.02 at 6 am

Unit: II Dr K Sarkar

Status of membrane: **Intact**/ruptured

If ruptured (time): Onset of labor pain: About 4 am

Complaint on admission: Labor pain with 37 weeks amenorrhea

On examination findings: Os: 2 cm, cervix: 50% taken up, FHR: 140/m, mother is in labor. BP: 120/80 mmHg, pulse: 78/m

#### Brief History

***Social:***

Education: Husband: IV Wife: Illiterate

Family members: 5 Support person: Mother-in-law

Occupation: Husband: Laborer Wife: Housewife

**Personal:** Any drug allergy – Nil

**Medical and surgical:**

Past: Nothing significant Present: Nothing significant

Family: Nothing significant

Diet: Last mealtime and contents: Taken tea and biscuits at 6 am

Bowel and bladder: Time of evacuation: Passed urine at 6.20 am, passed stool at 6.30 am

| *Past obstetric history* | | | | | | | *LCB* |
|---|---|---|---|---|---|---|---|
| **No. of pregnancy** | **Year** | **Abortion (If any mention with period)** | **Any problems during antenatal period** | **Mode of delivery (if C/S then specify the indication)** | **Sex of the baby with condition at birth (still birth/living)** | **Any problem during puerperium** | **Remarks (with the history of breastfeeding immunization contraceptives)** |
| | | Primi | Gravida | | | | |

## Present Obstetric History

Married for: 1 year only

Booked/unbooked: No. of antenatal check ups: 6

Immunization: Injection tetanus toxoid (TT) 2 doses taken

Total weight gain: 9 kg.

Any problem aroused during pregnancy: Yes/No

If yes, treatments given:

Nature of labor pain (with time): Started around 4 am. She complained a radiating pain from abdomen to thighs.

## Laboratory Reports

| | | |
|---|---|---|
| Blood | Group: A | Hb%: 9 g% |
| | Rh: +ve | PPBS/Fasting: 76 mg/dL |
| | | VDRL: Nonreactive |
| | Others: | |
| Urine | Sugar: Nil | Albumin: Nil |

USG report: Not done

## Physical Examinations

Vital signs: BP: 110/70 mmHg Pulse: 80/m Resp: 20/m Temp.: Normal General condition: Good

| | | |
|---|---|---|
| Eye: | **Pallor**/Normal | |
| Tongue: | Dehydrated/**Moist** | Hydration level: Normal |
| Breast: | Soft and secretary | Heart: NAD |
| Bladder: | Distended/**Evacuated** | Lung: NAD |
| Edema: | Nil | |

Any other specific findings: Nothing significant

Any other associated condition: Nothing significant

## Abdominal Examination

Inspection: Uterine ovoid is longitudinal. Pink striae are visible. No scar mark. Uterine contraction is present. Fetal movements are visible.

SFH: In cm—32 cm In weeks: 32 weeks. Abdominal girth: 100 cm.

Palpation: Fundal grip: A soft broad mass suggestive of buttocks.

Lateral grip: In left lateral grip of women a smooth, curved, resistant mass is felt suggestive of back and in right lateral grip knob-like structures suggestive of fetal limbs.

Pelvic grip: A smooth hard globular mass is felt suggestive of fetal head and descent is 3/5. Pawlik grip: Head is engaged.

Auscultation: FHR: 136 b/m

### Per Vaginal Examination/Vulval Inspection

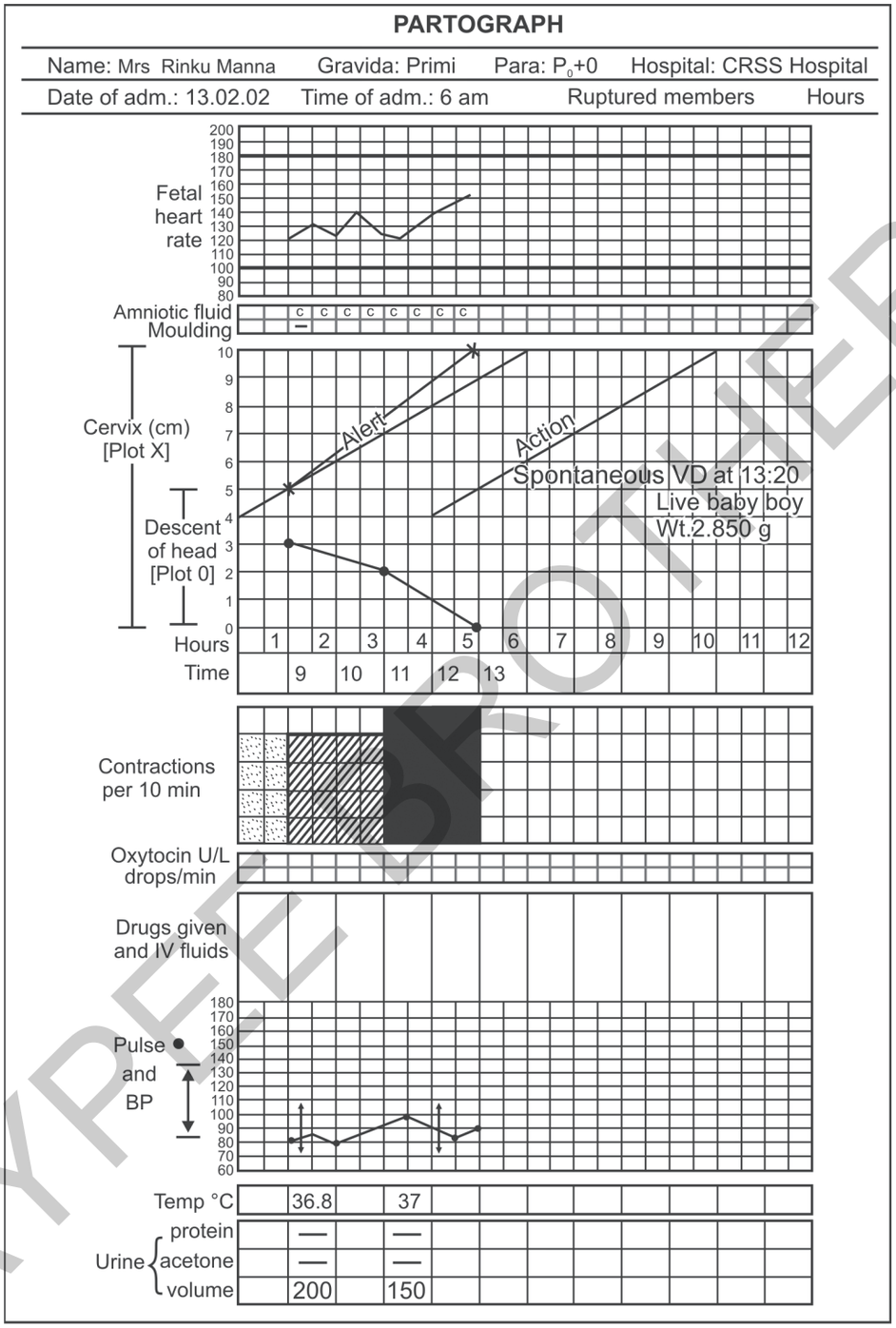
At 9 am → No bleeding. OS: 5 cm. Station: 1 Cervix: 90% taken up. Pelvis: Adequate. BOM: Intact.

**Remarks** (specifying presentation, position, engagement, etc.):

A full-term pregnant woman with true labor pain.

Finding reveals: position—LOA. Presentation: Vx, FHR: 136 b/m and regular.

All other findings are recorded in the partograph serially.




Color key for duration of contraction: <20 Seconds, 20-40 Seconds, >40 Seconds

Vertically there are 5 rooms, one room indicate one contraction, X Plot your first findings on alert line.

| | |
|---|---|
| ***Management during first stage of labor*** | |
| Time of onset of labor pain:<br>Time of full dilation of os: | About 4 am<br>12 noon |
| Rest/walk, diet, bowel, bladder, relief of pain (relaxation techniques/medication), General care, vulval toileting, bath, clothing, encouragement, assurance. Advices regarding Do's and Don'ts in 1st stage of labor, progress notes of labor, fetal and maternal condition (to be recorded in the partograph) | Mrs Rinku is instructed to walk or to adopt any position in which she feels comfortable and to practice breathing and relaxation technique during and after contraction. She has passed stool and urine. She has taken one cup of horlicks. No pain relieving drugs needed. She has taken a bath with soap and water. Garments changed. Reassurance given and instructed not to bear down. Her progress of labor is satisfactory.<br>Or write in brief only |
| ***Management during second stage of labor*** | |
| Patient preparation for delivery<br>Shifting to labor table, position of the women, catheterization<br>Instruction for bearing own<br>Progress notes of labor, fetal and maternal condition (to be recorded in the partograph).<br>Advices during 2nd stage of labor | Maintaining respectful maternity care in all step. Rinku is shifted to labor table at 12 noon. She is asked to lie on her back with knee flexed and legs/thighs apart. She is encouraged to bear down during contraction. Bladder is emptied. Only sips of water are given by mouth. Reassurance given. FHR checked 15 minutes interval. Mother's vital signs checked and noted on the partograph.<br>*or write only* (Shifted to labor table at 12 noon( (Only sips of water are given by mouth) |
| Unit preparation | Normal delivery tray prepared.<br>Baby receiving two pre-warmed towels ready. Injections, IV set, fluids bottle are kept ready. |
| Nurses preparation | Hand washing done. Cap, mask, gown is changed. A pair of sterile gloves worn. |
| ***Conduction of delivery (delivery note)*** | |
| **Mode of delivery: Time of delivery:**<br>Delivery of the head<br>(Specify if episiotomy required)<br>Care following delivery of head<br>Delivery of shoulders<br>Delivery of trunk | Spontaneous Vaginal Delivery done with episiotomy at 1:20 pm on 13.02.03. Vulval toileting done. Perineal guard is given. Injection lignocaine 1% 5 mL, infiltered in a fan shaped way. A right sided mediolateral episiotomy is given just before the crowning. Head is delivered in between contraction. Eyes and mouth are cleaned. There is no cord around the neck. Restitution occurred. Then after the external rotation of the head, it is pressed downwards to deliver anterior shoulder. After that posterior shoulder is delivered. Then in lateral flexion whole body is delivered and kept on mother's abdomen. Cord is clamped and cut. A full-term normal living baby boy delivered at 1:20 pm on 13.02.03. Baby cried immediately after birth.<br>*Or write only*<br>(A full-term normal living baby boy delivered at 1:20 pm on 13.02.03. Baby cried immediately after birth) |
| ***Management during third stage of labor*** | |
| Observation for signs of placental separation, Placenta: Expelled at membranes: Vulva, vagina and perineum inspection: Examination of placenta, membranes and cord (placenta and membranes completely expelled out at 1:30 pm) | A gush of bleeding with permanent lengthening of cord is seen vaginally. Uterus is hard and there is no indrawing of cord on pressure above symphysis pubis. Placenta is delivered by controlled cord traction. Placenta and membranes completely expelled out at 1:30 pm. A quick placental examination is done. |

| | |
|---|---|
| | It is intact. All cotyledons are present with complete amnion and chorion. Injection syntocinon 10 units given. Cervix, vagina, vulva, perineum is checked for any other tear. No tear found except clean episiotomy wound.<br>Or write only |
| Repairment of episiotomy/perineal tear/ cervical tear: | Episiotomy wound is repaired in three layers. There is no active bleeding. Uterus is hard, globular and mobile. Perineal care is given and antibiotic solution applied on wound. Per rectum examination done. Nothing abnormality found. Sterile vulval pad applied. Mother is kept comfortable. |
| **Sex of the newborn**: Baby boy<br>**Disc No. of the newborn**: 563<br>**Birth weight of the newborn**: 2.850 kg<br>**Condition of the newborn** (including a quick but thorough physical examination report specifying reflexes): | |
| Record if any resuscitation measures taken and time of cry:<br>**T (Maintenance of temperature):** Drying the baby<br>Removing wet linen<br>Providing radiant heat source<br>**A (Establish an open airway): Position:**<br>Suction:<br>**B (Initiate breathing):** Tactile stimulation:<br>**Sole flicking: Back-rubbing:**<br>**C (Maintenance of circulation):** Oxygenation:<br>**Respiration, heart rate, color of the baby:**<br>Further resuscitation measures taken:<br>**Use of PPV:**<br>**Use of ET tube: CPR:**<br>**Orogastric tube:**<br>**D (Medications given):** | Quick but thorough physical examination report<br>Baby cried immediately after birth. No resuscitation measures required.<br>General condition—good, posture—flexed. Well cried, alert. Skin—pink, texture—soft, smooth. Vernix present on back. Lanugo present on back, shoulders. No jaundice. Mongolian spot present at sacral region. FHR—136b/m, respiration—40/m, length—50 cm, HC—33 cm, CC—31 cm. Anterior fontanelles: Diamond shaped and measures 3 cm × 2.5 cm. No overriding of sutures. Hairs silky in nature. No moulding. No caput succedaneum or any injury. Eyes: Clean and healthy. Sclera: White, Iris: Dark gray, top of the pinna of ear is in a horizontal plane to the outer canthus. Pinna is firm, cartilage felt along with edge. Instant recoil of ear. Nasal passage is patent. No precocious teeth, no Epstein pearls, uvula in midline. No cleft lip or cleft palate. No glands palpable. Breast tissue more than 10 mm. Areola: Normal. Abdomen: Soft, no palpable mass. Umbilical cord is clean and no bleeding. 2 arteries and 1 vein are present. Labia majora well developed and completely cover the labia minora. No discharge. Urethral meatus is located above the vaginal orifice. No hip dislocation. Anus: Patent, Legs: 10 fingers of toes and sole creases present over 1/3rd portion. Grasp, moro, glabellar tap, rooting, sucking, Babinski—all reflexes are present. Muscle activity—normal Baby is normal.<br>Or write only<br>[Baby cried immediately after birth]<br>[FHR—136b/m, Respiration—40/m, Length—50 cm, HC—33 cm, CC—31 cm. Anterior fontanelles: Diamond shaped and measures 3 cm × 2.5 cm]<br>[Baby is normal] |
| **Total hours of labor: About 10 hours.**<br>1st stage: About 8 hours. 2nd stage: 1 hr 45 minutes.<br>3rd stage: 10 minutes. | |

| | |
|---|---|
| ***Medical treatments advised (if any):*** | |
| Capsule amoxicillin 500 mg QDS × 5 days | |
| Tablet brufen and tablet antacid 1 tablet BDPC × 3 days To apply betadine ointment locally. | Normal |
| ***Management of fourth stage of labor:*** | |
| Condition of mother: | Good BP: 110/80 mm of Hg. TPR: Afebrile, P—80b/m, R—20/m |
| Level of hydration: | Normal |
| Breast: | Soft and secretory |
| Bladder: | Emptied |
| Vaginal bleeding: | Lochia rubra is present in average amount |
| Uterus: | Hard, globular and mobile. SFH—14 cm |
| Episiotomy wound: | No active bleeding |
| Emotional response: | Normal |
| General care: | A cup of warm milk with two biscuits provided. Face and neck wiped with cold water. Advised to take rest |
| Condition of baby:<br>(With report of breastfeeding initiation) | No cord bleeding. Baby is put to breast. Baby is active |
| Mother was transferred to postnatal ward at 3 pm on 13.02.03. | |

# NURSING CARE PROCESS
# (FOR MOTHER BEFORE DELIVERY)

| *Nursing diagnosis* | *Expected outcomes* | *Nursing interventions (implementations)* | *Evaluation* |
|---|---|---|---|
| 1. Altered personal hygiene due to labor pain. | Expresses feeling of freshness and comfort. | • Encouraged to take a bath in the 1st stage. Advised to take a mouthwash.<br>• Sponging of face and neck is done in the 2nd stage. | She expresses refreshed. |
| 2. Altered nutrition and fluid and electrolyte balance due to restriction and perspiration in labor pain. | She will have nutrition, fluid and electrolyte in a balance state. | • Provided liquid diet—a glass of horlicks and water during latent phase. But only sips of water in the 2nd stage of labor. IV fluid with Ringer's solution is kept ready. | Hydration level: Normal. |
| 3. Acute pain related to physiological response to labor. | Modify behavior to decrease intensity of labor pain. | • Taught Lamaz method of breathing and relaxation technique.<br>• Instructed to relax after each contraction. Advised not to bear down in the 1st stage. Taught when and how to bear down in the 2nd stage of labor. | She is not crying loudly.<br><br>She expressed to pass stool during 2nd stage which expresses the spontaneous bear down pain. |
| 4. Potential altered elimination due to fetal head obstruction in the pelvis. | No bladder distension. | • Encouraged to empty the bladder and bowel.<br>• Encouraged to empty the bladder at least every hours. So, that catheterization can be avoided. | No bladder distension. Passed stool and urine. |
| 5. Discomfort related to positioning mobility due to labor pain. | Verbalizes comfort | • Positioned as per preference and comfort like leaning forward, supporting her weight on a table, walking, etc.<br>• Advised to take rest in a left lateral position while lying down and after rupture of membrane. | Verbalizes comfort on lying. |
| 6. Potential alteration in FHR due to fetal distress. | Early diagnosis of fetal asphyxia. | • Obstetrical examination done.<br>• Assessed fetal position, presentation and FHR.<br>• Maintained partograph. | No fetal asphyxia. FHR—140 b/m. |
| 7. Potential alteration in progress of labor. | No prolong labor. | • Per vaginal examination done. Assessed uterine contractions and recorded in the partograph.<br>• Maternal vital signs and FHR checked half hourly. | Good progress of labor. All findings suggest normal delivery. |

# NURSING CARE PROCESS
# (FOR MOTHER AFTER DELIVERY)

| *Nursing diagnosis* | *Expected outcomes* | *Nursing interventions (implementations)* | *Evaluation* |
|---|---|---|---|
| 1. Alteration of body system due to labor process | Normal body system. Vital signs within normal range<br>Fundus firm<br>Lochia scant to moderate rubra. | • Checked vital signs<br>• Checked dehydration level<br>• Checked fundal height and consistency<br>• Checked lochia—amount, color | BP: 110/80 mm Hg. Pulse: 88 b/m, R: 20/m. Fundal height: 13 cm. Uterus—hard, globular, mobile. Lochia rubra present in normal amount. |
| 2. Alteration in comfort due to after pain, uterine cramps, bleeding. | Mother experiences minimum discomfort. No signs of postpartum complication | • Provided comfortable positioning and advised early ambulation<br>• For uterine cramps—administered pain medication<br>• Assessed breast for engorgement Instructed mother to prevent breast engorgement. Encouraged proper breast emptying by giving colostrum and continue exclusive breastfeeding | Expressed better feelings.<br><br>Baby is put to breast |
| 3. Pain related to episiotomy suturing. | Mother verbalizes after relief with interventions<br>Pain at the level of toleration. Assess perineum swelling, redness, bleeding | • Assessed for pain relief in mother and administered pain medication<br>• Discussed reasons of pain and it's expected duration<br>• Inspected the sutured area for oedema, bleeding<br>• Perineal care provided | Suture area is normal. No unbearable pain present |
| 4. Altered nutrition and fatigue due to labor process. | Ensured nutrition and rest. | • Provided rest<br>• Provided a cup of warm milk with two biscuits.<br>• Provided support system for help. | Taking rest. |
| 5. Altered elimination pattern due to physiological process of labor. | No bladder distension. | • Encouraged to empty the bladder and bowel. | No bladder distension, measured the first void, mother asked for frequency and amount of void. |
| 6. Risk for infection due to episiotomy wound | No phlebitis, Homan's sign, episiotomy wound infection. | • Provided antibiotic as ordered. Checked for Homan's sign | No phlebitis, no Homan's sign, episiotomy wound normal. |

| *Nursing diagnosis* | *Expected outcomes* | *Nursing interventions (implementations)* | *Evaluation* |
|---|---|---|---|
| 7. Knowledge deficit on self-care | Mother states to whom to consult for postpartum check up. Mother verbalizes understanding of written and verbal instructions on self-care activities and breastfeeding | Provided verbal instructions about:<br>• Diet and exercises<br>• Personal hygiene<br>• Contraception<br>• Sexual activity<br>• Return of menstruation<br>• FP methods for spacing<br>• Signs of complication<br>• Baby care especially regarding hypothermia, cord infection, meconium, urine and immunization.<br>• Provided information about postpartum check-up | Verbalizes understanding of verbal instructions on self-care activities and breastfeeding. |
| 8. Alteration in family process for newborn baby | Parents will demonstrate good coping skills. Acceptance of role of parent. Demonstrate positive parenting behavior. | • Established mutual trust and respect. Taught parenting. Provided support system. | Demonstrate positive parenting behavior |

# Maternity Record Book

## A Practical Record Book of Obstetrics

### *Salient Features*

- Modified as per competency-based semester system of the revised INC syllabus.
- Provided examples to guide students during writing.
- Images are included wherever necessary for better understanding.
- Formats are simple, organized and easy-to-use.
- Observation of PPIUCD is added.
- Kangaroo mother care is added.
- Antenatal, postnatal and newborn care plans are added.
- Case presentation proforma is added.
- A helpful guide for students on the entire Obstetrical Nursing Practical paper.

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