HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (L&D)		
Document:	Departmental Policy and Procedure		
Title:	Conducting Normal Delivery		
Applies To:	All Obstetrics and Gynecology Staff		
Preparation Date:	January 08, 2025	**Index No:**	L&D-DPP-032
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1. PURPOSE:

1.1 To provide guidelines for a safe spontaneous vertex delivery of a newborn infant.

2. DEFINITIONS:

2.1 **Primigravida (PG)** – is a woman who is pregnant for the first time or has been pregnant one time.

3. POLICY:

3.1 A physician or a midwife may conduct a normal delivery for multiparous patient.
3.2 Primigravida patient to be delivered by the resident.
3.3 If labor commence before the 37th completed week of pregnancy, the pediatrician will be present for the delivery.
3.4 For the delivery, the midwife/physician will be assisted by another member of the labor ward staff preferably a midwife.
3.5 Monitor FHR and document time of 2nd degree on partogram and CTG.

4. PROCEDURE:

4.1 Once the cervix is fully dilated and the woman is in the expulsive phase of the second stage, encourage the woman to assume the position she prefers.
4.2 Ensure privacy.
4.3 Prepare the sterile delivery trolley.
4.4 Ensure the room is warm, switch on heater on the resuscitator and ensure all equipment is in working order.
4.5 Encourage the patient to push.
4.6 When the vertex is visible, wear sterile gloves and wash the external genitalia with sterile water and prepare sterile field.
4.6 Delivery of the head
- 4.6.1 Ask the woman to give only small pushes with contractions as the baby's head delivers.
- 4.6.2 To control birth of the head, place the fingers of one hand against the newborn head to keep it flexed (bent).
- 4.6.3 Continue gentle support at the perineum as the baby's head delivers.
- 4.6.4 Once the newborn's head delivers, ask the woman not to push.
- 4.6.5 Suction the newborn's mouth and nose.
- 4.6.6 Check around the newborn's neck for the umbilical cord:
  - 4.6.6.1 If the cord is around the neck but is loose, slip it over the newborn's head.
  - 4.6.6.1 If the cord is tight around the neck, doubly clamp and cut it before unwinding it from around the neck.

4.7 Completion of delivery:

4.7.1 Allow the newborn's head to turn spontaneously.
4.7.2 After the head turn, place a hand on each side of the newborn's head.
4.7.3 Tell the woman to push gently with the next contraction.
4.7.4 Reduce tears by delivering one shoulder at a time. Move the newborn's head posterior to deliver the shoulder that is anterior.
Note: If there is difficulty delivering the shoulders, suspect shoulder dystocia.
4.7.5 Lift the newborn's head anterior to deliver the shoulder that is posterior.
4.7.6 Support the rest of the newborn's body with one hand as it slides out.
4.7.7 Place the newborn on the mother's abdomen. Thoroughly dry the baby, wipe the eyes and assess the newborn's breathing.
Note: Most newborn to begin cry or breath spontaneously within 30 seconds of birth.
4.7.7.1 If the newborn is crying or breathing (chest rising at least 30 times per minute) leave the baby with the mother.
4.7.7.2 If the newborn does not start breathing within 30 seconds, **Shout for Help** and take steps to resuscitate the newborn.
4.7.8 Clamp and cut the umbilical cord. Obtain cord bloods for testing blood group, type and indirect Coomb's Test for Rh –ve mothers.
4.7.9 Ensure that the baby is kept warm and in skin to skin contact with the mother's chest. Wrap the baby in a soft, dry cloth, cover with a blanket and ensure the head is covered to prevent heat loss.
4.7.9.1 If the Mother is not well, ask an assistant to care for the newborn.
4.7.10 Palpate the abdomen to rule out the presence of additional newborns and proceed with active management of the third stage.
4.7.11 Active management of third stage.

4.8 The midwife/ nurse will carry out a complete exam of the newborn infant on the resuscitator in the delivery room. The newborn notes are completed including:

4.8.1 ID band x2 on the baby.
4.8.2 Recording time of birth, APGAR score, respiration and if resuscitation required, initiate same and call Paediatrician.
4.8.3 It is the responsibility of the Paediatrician to decide whether transfer the baby to NICU.
4.8.4 If the baby is stable, measurements of the baby are done, head circumference, length and weight.
4.8.5 Vitamin K is given intramuscularly.
4.8.6 The midwife then completes further identification of the infant, i.e. footprints included in the newborn Identification Form.
4.8.7 The initial physical examination will be done for detection of any obvious abnormalities.

4.9 Uterine Massage
4.9.1 Immediately massage the fundus of the uterus through the woman's abdomen until the uterus is contracted.
4.9.2 Repeat uterine massage every 15 minutes for the first 2 hours.
4.9.3 Ensure that the uterus does not become relaxed (soft) after you stop uterine massage.

4.10 Examination for tears
4.10.1 Examine the woman carefully and repair any tears to the cervix or vagina or repair episiotomy.

4.11 Note and document the time of delivery of the placenta.

4.12 Transfer the patient to the post-natal ward and hand the patient over the midwife allocated to her.

5. MATERIAL AND EQUIPMENT:

5.1 Sterile delivery pack including umbilical cord clamp
5.2 Sterile gloves
5.3 Sterile water
5.4 Entonox cylinder if needed for analgesia

5.5 10 ml syringe
5.6 21 gauge needle
5.7 Local Anaesthesia, e.g. lidocaine 1% with needle and syringe if episiotomy is anticipated
5.8 Newborn notes and ID band at the resuscitate which will be checked daily by Midwife
5.9 CTG monitoring

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurse
6.3 Midwife

7. APPENDICES:

7.1 History of Examination Form
7.2 Partogram

8. REFERENCES:

8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013
8.2 https://www.ncbi.nlm.nih.gov/pubmed/21702258

9. APPROVALS:

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KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ مستشفى:

Region: _____ المنطقة/المحافظة:

Dept./Unit: _____ القسم/الوحدة:

MRN: | | | | | | | | | | رقم الملف الطبي:

Name: _____ الاسم:

Nationality: _____ الجنسية:

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days العمر:

Date of Birth: ____/____/ 14____ H ____/____/ 20____ تاريخ الميلاد:

Gender: ☐ Male ☐ Female الجنس:

LABOR AND DELIVERY NURSING INITIAL ADMISSION ASSESSMENT FORM

I. ADMISSION DATE: (dd/mm/yy) ____/____/____ **TIME:** _____

II. ADMISSION DIAGNOSIS: _____

III. ADMISSION SOURCE: _____ **MODE OF ARRIVAL:** _____

☐ ER ☐ OPD/ Clinic _____ ☐ Walking ☐ Wheelchair
☐ others _____ ☐ Day care ☐ Stretcher / Bed ☐ Others _____

INFORMATION SOURCE: ☐ Patient ☐ Family ☐ Old Records ☐ Not Available

IV. ALLERGIES: ☐ Yes ☐ No **If yes , include medication , food and food products** _____

V. DATE & TIME:

Onset of: ☐ Labor ☐ ROM ☐ Bleeding

Booked: ☐ Yes ☐ No - If no, give reason: _____

Details	Name of Clinic		Gest. Age at first Booking	No. of visits
Hb	Bld. Grp.		RPR/VDRL	HIV

Problems at ANC _____

VI. VITAL SIGNS:

Temperature:	Respiratory Rate:	Weight:	Pain Score:
Pulse:	BP:	Height:	

VII. LEVEL OF CONCIOUSNESS: ☐ Alert ☐ Stupurous ☐ Lethargic ☐ Coma

VIII. POSITION: ☐ Prone ☐ Supine ☐ Fowler's ☐ Semi-fowler's ☐ Others: _____

IX. RESPIRATORY STATUS: (AIRWAY)

- Maintains own	☐ Mechanical Ventilator ☐ SIMV ☐ Spontaneous ☐ CMV FiO2 ____ O2 ____ RR ____ PEEP ____ TV ____	☐ ETT size ____ ☐ TT size ____ ☐ Oral airway size ____ ☐ Nasal airway size ____ ☐ Oxygen at ____ LPM ☐ Mask ☐ Nasal cannula

X. ABDOMINAL EXAMINATION:

Gestational Age	By dates		Palpation		SFH		Sonar	
Lie			Level of head (in fifths)					
Presentation			Attitude					
Liquor volume	Normal	Scanty	Polyhydramnios	EFW				

Contractions	Yes	No	Unsure	Less than 20 sec	20-40 sec	Greater than40 sec	FH	Normal	Abnormal	Absent

Type of FH abnormality

XI. VAGINAL EXAMINATION:

Speculum	Liquor			Blood		Cervix		
Digital Exam	Cervix	Thick	Thin	Oedematous	Not felt	Application	Good	Poor
Cervical Dilatation				Effacement		Position		
Presentation						Moulding	OP 0 + ++ +++	
Station	-3	-2	-1	0	+1 2 3		PP 0 + ++ +++	
Attitude	Well Flexed		Deflexed			Caput	Present	Not present
Liquor	Clear	MSL	Grade	I	II III	Blood Stain	Offensive	
Pelvic assessment	Adequate			Doubtful		Inadequate		

Name:_____ الاسم: | MRN: |_|_|_|_|_|_|_|_|_|_| رقم الملف الطبي:

I. STAGE OF LABOR:

❑ Stage 1	❑ Stage 2	❑ Stage 3	❑ Stage 4

RISK FACTORS

❑ Maternal	❑ Fetal	❑ Labor

Definitions:

ROM: Rupture of Membranes
CVS: Cadiovascular system
SFH: Symphysio-fundal height
FH: Fetal Heart
RPR: Rapid Plasma Reagent
MSL: Meconium stained liquor
HIV: Human Immunodeficiency virus
EFW: Estimated fetal weight
VDRL: Venereal disease research laboratory
OP : Occipito- posterior
PP : Parieto-parietal

II. BREATHING:

a. Rhythm
❑ Regular
❑ Irregular
❑ Paradoxical

b. Depth
❑ Normal
❑ Shallow
❑ Deep

c. Quality
❑ Normal
❑ Labored
❑ Stridor
❑ Crackles

d. Cough
❑ None
❑ Productive
❑ Non- productive

e. Bronchial/ Lung sound
❑ Normal
❑ Wheeze
❑ Rhonchi

III. CIRCULATION:

a. Pulse
❑ Regular ❑ Irregular
❑ Normal ❑ Weak
❑ Bounding

b. Skin
❑ Normal ❑ Pale ❑ Flushed
❑ Warm ❑ Cyanotic ❑ Jaundice
❑ Mottled ❑ Cool ❑ Dry
❑ Diaphoretic ❑ Oedema

c. IV Fluids .....
at .....**ml. level** .....**drops per minute**
IV Fluids .....**at** .....
cc. level .....**drops per minute**

IV. NUTRITION:

Diet:
❑ Regular
❑ Special
❑ Fluid restriction
Amount: .....

Appetite:
❑ Good
❑ Fair
❑ Poor
Comment: .....

Alternative route:
❑ NGT (size) .....
❑ GT (size) .....
❑ TPN .....

Difficulties:
❑ Swallowing
❑ Nausea
❑ Vomiting
❑ Indigestion

Nutritional Screening:
(Refer to dietitian if any of the below apply)
❑ Malabsorption
❑ Diabetes
❑ Renal disease
❑ Liver disease
❑ BMI less than19 or greater than 40
❑ Unable to take oral feeds
❑Others: .....
Referred: ❑ Yes ❑ No

V. ELIMINATION:

a. Bowel movement
❑ Normal ❑ Loose
❑ Constipation ❑ Colostomy
❑ Diarrhea

b. Urine
❑ Normal ❑ Amber
❑ Polyuria ❑ Cloudy
❑ Oliguria ❑ Hematuria
❑ Foley catheter Fr .....

VI. OTHERS: (Gastric tubes, dressing, restraint (cuff), pressure sore) .....

XVIII. ADOLESCENT ASSESSMENT (13-17 years old) - Not Applicable

Smoking: ❑ Yes ❑ No If yes, how many cigarettes each day?.....
Alcohol: ❑ Yes ❑ No If yes, how often?...../week
Use of "street drugs" such as marijuana, ecstacy and others? ❑ Yes ❑ No If yes, which ones?.....
Psychosexual problems: ❑ Yes ❑ No Others:.....

NOTE: Please fill-up the data required completely and legibly. Put check (√) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page.

RN Initial/Date/Time:.....

Name:_____ :الاسم	MRN: رقم الملف الطبي:

XIX. MEDICATIONS BROUGHT FROM HOME: (Include Homeopathic Remedies) ❑ No ❑ Yes

Medication	Dose	Route	Frequency	Last Dose	If unable to take, why?

XX. LOCATION OF MEDICATION:

❑ None ❑ Given to Pharmacy ❑ Given to family ❑ Given to patient care area

XXI. FUNCTIONAL SCREENING:

If patient needs assistance with any of the following refer to rehabilitation Date:.....

Physical therapy	❑ Mobility in bed	❑ Transfers	❑ Walking
Occupational therapy	❑ Eating	❑ Toileting	❑ Yes ❑ No
	❑ Washing	❑ Dressing	❑ Transfers
Speech therapy	❑ Swallowing		

XXII. PAIN ASSESSMENT SCALE:

A) NUMERICAL RATING SCALE: Pain Score 0-10 (0-nopain), (5- moderate pain), (10-worst possible pain)

PAIN SCORE:_____

B) WONG BAKER PAIN SCALE: (Please tick appropriate answer from "a" and "e" and fill up the questions ask from "b" to "d").

0 2 4 6 8 10

Intensity:

❑ 0 No pain ❑ 1-2 Mild pain, Annoying ❑ 3-4 Nagging pain, Uncomfortable ❑ 5-6 Miserable
❑ 7-8 Intense, Dreadful, Horrible ❑ 9-10Worst pain, Possible

C) BEHAVIORAL PAIN SCALE (To assess pain in ventilated, unconcious and/or sedated patients, please write appropriate answer and sum up).

CATEGORY	DESCRIPTION	SCORE	Patient's Score
FACIAL EXPRESSION	Relaxed	1	
	Partially tightened (e.g. brow lowering)	2	
	Fully tightened (e.g. eyelid closing)	3	
	Grimacing	4	
UPPER LIMBS	No movement	1	
	Partially bent	2	
	Fully bent, with finger flexion	3	
	Permanently retracted	4	
COMPLIANCE WITH VENTILATION	Tolerating movement	1	
	Coughing with movement	2	
	Fighting with ventilator	3	
	Unable to control ventilation	4	
PATIENT'S TOTAL PAIN SCORE			

Scoring: - 0-3 No pain - 4-6 Mild pain - 7-9 Moderate pain - 10-12 Severe pain

a.) Location: Where does it hurt?..... **b.) Onset:** When did the pain start?.....
c.) Duration: How long have you had this pain?.....
d.) Quality: ❑ Constant, on and off ❑ Radiating ❑ Dull or sharp ❑ Burning or pressure

XXIII. "BRADEN SCALE" SKIN RISK ASSESSMENT

(Write the appropriate answer and sum up from "a" to "f" to get the total score)

Category		Parameters	Score	Patients Score
a)	Sensory perception	No impairment	4	
		Lightly limited	3	
		Very limited	2	
		Completely limited	1	
b)	Moisture	Rarely moist	4	
		Occasionally moist	3	
		Very moist	2	
		Constantly moist	1	
c)	Activity	Walks frequently	4	
		Walks occasionally	3	
		Chair Bound	2	
		Bedfast	1	

Name:_____ الاسم:	MRN: رقم الملف الطبي:

d)	Mobility	No limitations	4	
		Slightly limited	3	
		Very limited	2	
		Completely immobile	1	
e)	Nutrition	Excellent	4	
		Adequate	3	
		Probably inadequate	2	
		Very poor	1	
f)	Shear & Friction	No apparent problem	4	
		Potential problem	3	
		Problem	2	
		Significant problem	1	
"BRADEN SCALE" TOTAL PATIENT'S SKIN RISK ASSESSMENT SCORE				

Score of less than 16, patient is "at risk" for the development of pressure sores.

XXIV. "MORSE" FALLS RISK ASSESSMENT(Write appropriate answer and sum up from "a" to "f" to get the total score)

Category	Parameters	Score	Patient's Score
a)History of falling (immediate & in not less than three (3) month time)	No	0	
	Yes	25	
b) Secondary diagnosis (include meds risk) diuretics; benzodiazepines antihypertensives; corticosteroids'; drugs treating diabetes mellitus; polypharmacy (4 or more drugs)	No	0	
	Yes	15	
c) Ambulatory aids	None/ Bed rest/ Nurse assist	0	
	Crutches/ stick/frame	15	
	Furniture/walls	30	
d) Intravenous therapy	No	0	
	Yes	20	
e) Gait	Normal/ Bed rest/ Wheelchair	0	
	Weak	10	
	Impaired	20	
f.)Mental status	Oriented to own ability	0	
	Over estimates/ forget limitations	15	
"MORSE" FALLS TOTAL PATIENT'S RISK ASSESSMENT SCORE			

SCORING: 0-25 (Low risk) 30-55 (Medium risk) >55 (High risk)

XXV. PSYCHOSOCIAL

Unusual concerns about patient's physical/social status: ❑ Yes ❑ No ❑ Physician notified ..... (Date/Time).....

XXVI. SOCIAL STATUS

❑ Single ❑ Married ❑ Lives alone ❑ Lives with family ❑ Lives with friends

XXVII. ORIENTATION TO UNIT / ENVIRONMENT

❑ Toilets ❑ Patient handbook ❑ Bed control / rails	❑ Phone ❑ Visiting Time ❑ Call Bell	❑ ID Band ❑ Patient's rights/responsibilities ❑ Safety Measures	❑ Visitors policy ❑ Smoking policy

XXVIII. EDUCATIONAL/GENERAL NEEDS

Repeated, unscheduled admissions	❑ Yes	❑ No
Newly diagnosed chronic/terminal illness	❑ Yes	❑ No
Family education needed for in-home care	❑ Yes	❑ No

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RN Initial/Date/Time:.....

Name: _____ :الاسم	MRN: _____ :رقم الملف الطبي

XXIX. PHYSICAL DEFICITS (Please write appropriate information in example.)

Cardiovascular: ❑ Yes ❑ No example.....	Musculoskeletal/Mobility: ❑ Yes ❑ No example.....
Respiratory: ❑ Yes ❑ No example.....	Skin/Wound: ❑ Yes ❑ No example.....
Neurological: ❑ Yes ❑ No example.....	Cognitive/Mental: ❑ Yes ❑ No example.....
Sensory/Speech: ❑ Yes ❑ No example.....	Endocrine: ❑ Yes ❑ No example.....
Gastrointestinal/Nutritional: ❑ Yes ❑ No example.....	Language Barrier: ❑ Yes ❑ No example.....
Genitourinary: ❑ Yes ❑ No example.....	Other Concerns:.....

XXX. DISCHARGE PLANNING

SOCIOECONOMIC NEEDS:		
Lack of needed caregiver; family support	❑ Yes	❑ No
At risk of abuse or neglect	❑ Yes	❑ No
Inadequate resources: insurance, financial	❑ Yes	❑ No
Foster parent, guardian etc.	❑ Yes	❑ No
Inadequate or inappropriate post hospital plans	❑ Yes	❑ No
ENVIRONMENTAL NEEDS:		
Change in living arrangements	❑ Yes	❑ No
In-home care or equipment	❑ Yes	❑ No
Vocational and/or role loss	❑ Yes	❑ No
Inability to complete ADL	❑ Yes	❑ No
PSYCHOLOGICAL NEEDS:		
Potential of harm to self or others	❑ Yes	❑ No
Suspected drug or alcohol abuse	❑ Yes	❑ No
Inappropriate patient/family behaviors	❑ Yes	❑ No
Difficult adjustment to diagnosis (acceptance or diagnosis)	❑ Yes	❑ No

REFERRAL INDICATED: ❑ Yes ❑ No

Referral sent to: ❑ Social Services ❑ Home Care ❑ Other .....

High risk indicated but no referral sent, why? .....

.....

.....

Name: _____ :الاسم	MRN: رقم الملف الطبي:

XXXI. PROBLEM SUMMARY LIST "ACTION : REFER TO MULTIDISCIPLINARY PLAN OF CARE FORM"

SERIAL NUMBER	ASSESSMENT / PATIENT NEEDS FINDINGS

RN NAME _____ Signature _____ Designation _____

Job number _____ Date (dd/mm/yy) _____ Time _____

NOTE: Please fill-up the data required completely and legibly. Put check (√) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page. Draw a line across empty spaces.

Name:_____ الاسم:_____ | MRN: |_|_|_|_|_|_|_|_|_|_| رقم الملف الطبي:

PARTOGRAM

Date & time of admission: | Consultant:

E.D.D: | Parity:

Special instructions:

FETAL HEART RATE

0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

190 180 170 160 150 140 130 120 110 100 90 80 70 60

Duration of rupture of membranes (hrs) | Liquor | Moulding

CERVICAL DILATATION

10 9 8 7 6 5 4 3 2 1

Duration of labor: 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

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