AFFIX PASSPORT-SIZED UNIFORMED PHOTO HERE

**OBSTETRICS AND GYNAECOLOGY NURSING**
**PRIVILEGING LOGBOOK**
**AT**
**MINISTRY OF HEALTH MALAYSIA HOSPITALS**

Name : _____

IC Number : _____

Hospital : _____

Ward/Unit/Department : _____

Programme Commencement Date : _____

Programme Completion Date : _____

# OBSTETRICS AND GYNAECOLOGY NURSING LOGBOOK FOR PRIVILEGING

## 1. INTRODUCTION

This logbook is designed to record all training activities for nurses who are required to undergo the privileging programme while serving in respective wards or units in Obstetrics and Gynecology Departments. It provides checklists of procedures that require privileging.

A total of **sixteen (16) procedures** have been identified to strengthen nurses' competencies in performing Obstetrics and Gynecological procedures. To ensure competency and maintain safety standards, nurses are required to undergo three stages of skill acquisition according to the specified number of cases: observation (observe), assistance (assist), and performance (perform).

## 2. OBJECTIVES

i. To ensure that nurses in respective wards, units, or departments acquire sufficient knowledge and competency to perform required procedures safely and effectively.

ii. To ensure that nurses performing these procedures are adequately trained, supervised and competent.

iii. To enhance the quality of care and promote safety among patients and healthcare personnel.

## 3. ASSESSORS

The assessment of clinical practice for each procedure in the Department of Obstetrics and Gynecology shall be conducted by appointed assessors, consisting of designated nurses from the respective facilities. Each procedure must be directly observed and evaluated by the assessor, who shall record the assessment in this Logbook once the nurse being assessed is deemed competent in performing the procedure.

## 4. CANDIDATE ELIGIBILITY

This log book is intended for nurses (various grades) without midwifery qualifications who have:

i. Successfully completed the Mentoring Programme.
ii. Fulfilled all specific hospital/facility requirements.

**LIST OF PROCEDURES**

| No. | Procedure | Number of Skill Acquisition (Required) | | | Remarks |
|---|---|---|---|---|---|
| | | **O** | **A** | **P** | |
| 1. | *History taking of antenatal mother* | 3 | 3 | 5 | **CORE** |
| 2. | *Physical examination of antenatal mother* | 3 | 3 | 5 | **OPTIONAL** |
| 3. | *Perform Cardiotocography (CTG)* | 3 | 3 | 5 | **CORE** |
| 4. | *Assess fetal heart rate (Daptone/ doppler device)* | 3 | 3 | 5 | **CORE** |
| 5. | *Timing uterine contraction* | 3 | 3 | 5 | **CORE** |
| 6. | *Fetal movement chart education* | 3 | 3 | 5 | **CORE** |
| 7. | *Administration IVI Magnesium Sulfate* | 3 | 3 | 5 | **CORE** |
| 8. | *Administration IVI Labetolol* | 3 | 3 | 5 | **CORE *** |
| 9. | *Administration IVI Hydralazine* | 3 | 3 | 5 | **CORE *** |
| 10. | *Administration IV / IM iron therapy* | 3 | 3 | 5 | **CORE** |
| 11. | *Heel dextrostix for newborn baby* | 3 | 3 | 5 | **OPTIONAL** |
| 12. | *Heel TSB for newborn baby* | 3 | 3 | 5 | **OPTIONAL** |
| 13. | *Care for baby under phototherapy* | 3 | 3 | 5 | **OPTIONAL** |
| 14. | *Top and tail* | 3 | 3 | 5 | **CORE** |
| 15. | *Postnatal care mother* | 3 | 3 | 5 | **CORE** |
| 16. | *Postnatal care baby* | 3 | 3 | 5 | **CORE** |

**Legend:**
O: OBSERVATION A: ASSIST: P: PERFORM
***** *To conduct a simulation session if a real case is unavailable*

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**PROCEDURE 1: HISTORY TAKING OF ANTENATAL MOTHER**

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 1: HISTORY TAKING OF ANTENATAL MOTHER

Nurse's name: ……

Identification card no: …….

Tick (√) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Greet mother and introduce self | | | | | | | | | | | |
| 2. | Observe mother's well-being | | | | | | | | | | | |
| 3. | Invite mother to sit down | | | | | | | | | | | |
| 4. | Explain the purpose of the procedures | | | | | | | | | | | |
| 5. | Obtain from mother's and spouse's identification cards and marriage certificate | | | | | | | | | | | |
| | | | | | | | | | | | | |
| 6. | Obtain personal particulars: | | | | | | | | | | | |
| | 6.1 Name | | | | | | | | | | | |
| | 6.2 IC number | | | | | | | | | | | |
| | 6.3 Nationality | | | | | | | | | | | |
| | 6.4 Date of birth | | | | | | | | | | | |
| | 6.5 Ethnic group | | | | | | | | | | | |
| | 6.6 Occupation | | | | | | | | | | | |
| | 6.7 Home address and phone number | | | | | | | | | | | |
| | 6.8 Education level | | | | | | | | | | | |
| 7. | Spouse's particulars: | | | | | | | | | | | |
| | 7.1 Name | | | | | | | | | | | |
| | 7.2 IC number | | | | | | | | | | | |
| | 7.3 Occupation | | | | | | | | | | | |
| | 7.4 Home address and phone number | | | | | | | | | | | |
| 8. | Marital Status: | | | | | | | | | | | |
| | 8.1 Married | | | | | | | | | | | |
| | 8.2 Unmarried | | | | | | | | | | | |
| | 8.3 Widow | | | | | | | | | | | |
| | 8.4 Divorced | | | | | | | | | | | |
| 9. | Duration of marriage | | | | | | | | | | | |
| 10. | Referral : | | | | | | | | | | | |
| | 10.1 Referred by | | | | | | | | | | | |
| | 10.2 purpose of referral | | | | | | | | | | | |

**PROCEDURE 1: HISTORY TAKING OF ANTENATAL MOTHER**

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 11. | Medical history : | | | | | | | | | | | |
| | 11.1 Diabetes | | | | | | | | | | | |
| | 11.2 Hypertension | | | | | | | | | | | |
| | 11.3 Cardiac disease | | | | | | | | | | | |
| | 11.4 Asthma | | | | | | | | | | | |
| | 11.5 Epilepsy | | | | | | | | | | | |
| | 11.6 Thyroid | | | | | | | | | | | |
| | 11.7 Renal disease | | | | | | | | | | | |
| | 11.8 Tuberculosis | | | | | | | | | | | |
| | 11.9 HIV infection | | | | | | | | | | | |
| | 11.10 Thalasemia | | | | | | | | | | | |
| | 11.11 Anemia | | | | | | | | | | | |
| | 11.12 Ohers: - allergy | | | | | | | | | | | |
| 12. | Surgical history (please specify) | | | | | | | | | | | |
| | 12.1 General surgery - abdominal | | | | | | | | | | | |
| | 12.2 Orthopaedic surgery - pelvic, fractures | | | | | | | | | | | |
| | 12.3 Gynaecology surgery - myomectomy | | | | | | | | | | | |
| 13. | Family history: | | | | | | | | | | | |
| | 13.1 Medical problems | | | | | | | | | | | |
| | 13.2 Twin delivery | | | | | | | | | | | |
| 14. | Menstrual history | | | | | | | | | | | |
| | 14.1 Menarche | | | | | | | | | | | |
| | 14.2 Cycle | | | | | | | | | | | |
| | 14.3 Duration | | | | | | | | | | | |
| | 14.4 Amount | | | | | | | | | | | |
| 15. | Family planning history: | | | | | | | | | | | |
| | 15.1 Types | | | | | | | | | | | |
| | 15.2 Stopped –year/month | | | | | | | | | | | |
| 16. | Pap Smear | | | | | | | | | | | |

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 17. | Obtain past obstetrical history: | | | | | | | | | | | |
| | 17.1 Parity-gravida and para | | | | | | | | | | | |
| | 17.2 Year of birth and spacing | | | | | | | | | | | |
| | 17.3 Pregnancy and any problem | | | | | | | | | | | |
| | 17.4 Gestation (preterm/term/posterm) | | | | | | | | | | | |
| | 17.5 Place of delivery | | | | | | | | | | | |
| | 17.6 Type of delivery | | | | | | | | | | | |
| | 17.7 Labour and any complications | | | | | | | | | | | |
| | 17.8 Puerperium and any complications | | | | | | | | | | | |
| 18. | Baby : | | | | | | | | | | | |
| | 18.1 Sex | | | | | | | | | | | |
| | 18.2 Birth weight | | | | | | | | | | | |
| | 18.3 Types of feeding and duration | | | | | | | | | | | |
| | 18.4 Health status | | | | | | | | | | | |
| 19. | Present pregnancy: | | | | | | | | | | | |
| | 19.1 Gravida | | | | | | | | | | | |
| | 19.2 Para | | | | | | | | | | | |
| | 19.3 LNMP-verify | | | | | | | | | | | |
| | 19.4 EDD | | | | | | | | | | | |
| 20. | Other relevant issues : check immunization status | | | | | | | | | | | |
| 21. | Received any blood transfusion procedure | | | | | | | | | | | |
| 22. | Maintained eye contact throughout procedure | | | | | | | | | | | |
| 23. | Documentation | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

**CHECKLIST PROCEDURE 1: HISTORY TAKING OF ANTENATAL MOTHER**

FORMULA : __TOTAL_YES___ X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment: .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 2: PHYSICAL EXAMINATION OF ANTENATAL MOTHER

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 2: PHYSICAL EXAMINATION OF ANTENATAL MOTHER

Nurse's name: ……

Identification card no: ……

Tick (√) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Study the antenatal record | | | | | | | | | | | |
| 2. | Greet mother and introduce self | | | | | | | | | | | |
| 3. | Explain the purpose of the procedure | | | | | | | | | | | |
| 4. | Mother assessment | | | | | | | | | | | |
| | 4.1 Observe gait, stature and general condition of mother | | | | | | | | | | | |
| | 4.2 weight | | | | | | | | | | | |
| | 4.3 height | | | | | | | | | | | |
| | 4.4 blood pressure reading | | | | | | | | | | | |
| | 4.5 urine protein | | | | | | | | | | | |
| | 4.6 urine sugar | | | | | | | | | | | |
| 5. | Inquire about: | | | | | | | | | | | |
| | 5.1 general health | | | | | | | | | | | |
| | 5.2 rest | | | | | | | | | | | |
| | 5.3 sleep | | | | | | | | | | | |
| | 5.4 appetite | | | | | | | | | | | |
| | 5.5 dental carries | | | | | | | | | | | |
| | 5.6 minor disorders | | | | | | | | | | | |
| | 5.7 any other complaint | | | | | | | | | | | |
| 6. | Assist mother onto the couch for examination | | | | | | | | | | | |
| 7. | Provide privacy and comfort | | | | | | | | | | | |
| 8. | Wash hands | | | | | | | | | | | |
| 9. | Conduct physical examination systematically: | | | | | | | | | | | |
| | 9.1 note condition of hair | | | | | | | | | | | |
| | 9.2 oral cavity<br>9.3 note any dental carries | | | | | | | | | | | |
| | 9.4 Neck : enlarged thyroid gland prominent jugular vein | | | | | | | | | | | |
| | 9.5 Observe for tremors, colour of nail beds, oedema and shape | | | | | | | | | | | |

**CHECKLIST PROSEDURE 2: PHYSICAL EXAMINATION OF ANTENATAL MOTHER**

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 10. | Perform breast examination: | | | | | | | | | | | |
| | 10.1 Inspect: contour/skin changes | | | | | | | | | | | |
| | 10.2 nipples | | | | | | | | | | | |
| | 10.3 palpate for lump | | | | | | | | | | | |
| 11. | Perform abdominal examination: | | | | | | | | | | | |
| | 11.1 Inspect | | | | | | | | | | | |
| | 11.2 size | | | | | | | | | | | |
| | 11.3 shape | | | | | | | | | | | |
| | 11.4 skin changes | | | | | | | | | | | |
| | 11.5 scar | | | | | | | | | | | |
| 12. | Perform abdominal palpation: | | | | | | | | | | | |
| | 12.1 Fundal Palpation: | | | | | | | | | | | |
| | 12.2 Determine fundal height / correspond to POA | | | | | | | | | | | |
| | 12.3 identify poles | | | | | | | | | | | |
| | 12.4 Lateral Palpation: | | | | | | | | | | | |
| | 12.5 lie | | | | | | | | | | | |
| | 12.6 fetal back | | | | | | | | | | | |
| | 12.7 Pelvic Palpation: | | | | | | | | | | | |
| 13. | Presentation : engagement | | | | | | | | | | | |
| 14. | Auscultation | | | | | | | | | | | |
| | 14.1 Fetal heart rate | | | | | | | | | | | |
| | 14.2 Rhythm | | | | | | | | | | | |
| | 14.3 Tone | | | | | | | | | | | |
| 15. | Examine both lower limbs : | | | | | | | | | | | |
| | 15.1 Deformity | | | | | | | | | | | |
| | 15.2 Oedema at pedal/ankle/pre-tibia/tibia | | | | | | | | | | | |
| | 15.3 Varicose vein | | | | | | | | | | | |
| 16. | Inquire if any abnormal vaginal discharge | | | | | | | | | | | |
| 17. | Inquire about fetal movement | | | | | | | | | | | |
| 18. | Inform mother of the findings | | | | | | | | | | | |
| 19. | Advise mother accordingly | | | | | | | | | | | |
| 20. | Record and report the findings | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

**PROSEDURE 2: PHYSICAL EXAMINATION OF ANTENATAL MOTHER**

FORMULA : TOTAL YES X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment: ….....
.

….....

….....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 3: PERFORM CARDIOTOCOGRAPHY (CTG)

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 3: PERFORM CARDIOTOCOGRAPHY (CTG)

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Greet mother and introduce self | | | | | | | | | | | |
| 2. | Explain the purpose of the procedure | | | | | | | | | | | |
| 3. | Ask mother to empty bladder | | | | | | | | | | | |
| 4. | Give mother a privacy | | | | | | | | | | | |
| 5. | Position mother in recumbent | | | | | | | | | | | |
| 6. | Perform an abdomen palpation to locate | | | | | | | | | | | |
| | 6.1 Fundus of the uterus | | | | | | | | | | | |
| | 6.2 Fetal back | | | | | | | | | | | |
| 7. | Place the Toco Transducer / uterine activity sensor at the fundus | | | | | | | | | | | |
| 8. | Apply ultrasound gel onto the Doppler Transducer and placed on the abdomen, adjust until a clear fetal heart sound is heard | | | | | | | | | | | |
| 9. | Secure both transducers / sensor in place | | | | | | | | | | | |
| 10. | Lie mother in semi fowler position | | | | | | | | | | | |
| 11. | Record the CTG tracing for 20 minutes or as ordered by doctor | | | | | | | | | | | |
| 12. | Observe the CTG tracing intermittently | | | | | | | | | | | |
| 13. | Inform Doctor immediately if any suspicious tracing detected | | | | | | | | | | | |
| 14. | Record mother's particulars on the tracing | | | | | | | | | | | |
| | 14.1 Name | | | | | | | | | | | |
| | 14.2 Registration number | | | | | | | | | | | |
| | 14.3 Date | | | | | | | | | | | |
| | 14.4 Time | | | | | | | | | | | |
| 15. | Show the CTG graph to doctor for evaluation and further management | | | | | | | | | | | |
| 16. | Documentation | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

**PROCEDURE 3: PERFORM CARDIOTOCOGRAPHY (CTG)**

FORMULA : TOTAL YES X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment: .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 4: ASSESS FETAL HEART RATE (DAPTONE / DOPPLER DEVICE)

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 4: ASSESS FETAL HEART RATE (DAPTONE/ DOPPLER DEVICE)

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Great mother and introduce self | | | | | | | | | | | |
| 2. | Explain the purpose of the procedure | | | | | | | | | | | |
| 3. | Give mother a privacy | | | | | | | | | | | |
| 4. | Put mother in recumbent position | | | | | | | | | | | |
| 5. | Cover mother's abdomen with draw sheet | | | | | | | | | | | |
| 6. | Expose mother's abdomen until symphysis pubis | | | | | | | | | | | |
| 7. | Perform an abdominal palpation | | | | | | | | | | | |
| 8. | Locate upper back of fetus | | | | | | | | | | | |
| 9. | Place the daptone | | | | | | | | | | | |
| 10. | Calculate fetus heart rate in 1 minute | | | | | | | | | | | |
| 11. | Heart beat : normal:110/ min - 160/ min | | | | | | | | | | | |
| 12. | Rhythm | | | | | | | | | | | |
| | 12.1 Regular | | | | | | | | | | | |
| | 12.2 Strong | | | | | | | | | | | |
| 13. | Show mother fetus' heart rate | | | | | | | | | | | |
| 14. | Comfort mother | | | | | | | | | | | |
| 15. | Document in partogram chart or labour progress chart | | | | | | | | | | | |
| 16. | Inform doctor promptly if any abnormality | | | | | | | | | | | State NA if action not needed |
| | TOTAL | | | | | | | | | | | |

## PROCEDURE 4: ASSESS FETAL HEART RATE (DAPTONE/ DOPPLER DEVICE)

FORMULA : TOTAL YES X 100%=
TOTAL PROCEDURE
(minus 'NA' if action not needed)

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment: - .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 5: TIMING OF UTERINE CONTRACTION

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 5: TIMING OF UTERINE CONTRACTION

Nurse's name :……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Greet mother and introduce self | | | | | | | | | | | |
| 2. | Explain the purpose of the procedure | | | | | | | | | | | |
| 3. | Provide privacy to mother | | | | | | | | | | | |
| 4. | Expose abdominal area | | | | | | | | | | | |
| 5. | Feel for contraction at fundus | | | | | | | | | | | |
| 6. | Timing contraction for 10 minutes: | | | | | | | | | | | |
| | 6.1 frequency count in 10 minutes | | | | | | | | | | | |
| | 6.2 duration count in a minute | | | | | | | | | | | |
| | 6.3 strength during contraction | | | | | | | | | | | |
| 7. | Documentation in partogram or labour progress chart | | | | | | | | | | | |
| 8. | Comfort the mother | | | | | | | | | | | |
| 9. | Inform Doctor the finding | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

**PROCEDURE 5: TIMING OF UTERINE CONTRACTION**

FORMULA : __TOTAL_YES___ X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment:- .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 6: FETAL MOVEMENT CHART EDUCATION

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 6: FETAL MOVEMENT CHART EDUCATION

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Greet mother and introduce self | | | | | | | | | | | |
| 2. | Explain the purpose of the procedure | | | | | | | | | | | |
| 3. | **Explain to mother:**<br>A movement or a series of movements at one time and sub-sequences cessation is considered as one fetal movement.<br>Normal fetal movement is at least 10 times within 12 hours in a day. | | | | | | | | | | | |
| 4. | **Teach mother:**<br>To commence the counting of fetal movement at the same time everyday for 12 hours till 10 counts achieved. | | | | | | | | | | | |
| 5. | Inform mother to complete fetal movement chart daily | | | | | | | | | | | |
| 6. | Record on the fetal movement chart according to the local practice:<br>tick for each fetal movement | | | | | | | | | | | |
| 7. | Record the time when 10 fetal movements is completed | | | | | | | | | | | |
| 8. | Inform mother to seek medical advice if fetal movement is less than ten times in 12 hours / intensity of fetal movement varies from normal fetal movement pattern | | | | | | | | | | | |
| 9. | Obtain feedback from mother | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

## PROCEDURE 6: FETAL MOVEMENT CHART EDUCATION

FORMULA : __TOTAL_YES___ X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment: .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 7: ADMINISTRATION INTRAVENOUS INFUSION MAGNESIUM SULPHATE (Mg SO4)

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 7: ADMINISTRATION INTRAVENOUS INFUSION MAGNESIUM SULPHATE (Mg SO4)

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | **PRE PROCEDURE** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** | |
| 1. | Receive written instructions from the Doctor | | | | | | | | | | | |
| 2. | Explain to the patient the procedure that will be performed | | | | | | | | | | | |
| 3. | Ensure the branula size is either 16G or 18G is inserted | | | | | | | | | | | |
| | **INTRA PROCEDURE** | | | | | | | | | | | |
| 4. | Make sure it is the right patient. Ask for the patient's name and make sure it matches with the identification tag | | | | | | | | | | | |
| 5. | Wash hands | | | | | | | | | | | |
| 6. | Dilute the drug and label according to current protocol for loading dose or maintenance dose. | | | | | | | | | | | |
| 7. | Check vital signs and records: Every 15 minutes for loading dose | | | | | | | | | | | |
| 8. | Every 30 minutes for maintenance dose | | | | | | | | | | | |
| 9. | For pregnant mothers, observation of the fetal heart rate is done every 30 minutes. | | | | | | | | | | | |
| | **POST PROCEDURE** | | | | | | | | | | | |
| 10. | Pay attention to the signs of magnesium toxicity such as; | | | | | | | | | | | |
| | 10.1 No patella reflex | | | | | | | | | | | |
| | 10.2 Respiratory rate < 16/minute | | | | | | | | | | | |
| | 10.3 Urine output < 30mls/ hour | | | | | | | | | | | |
| 11. | Document in | | | | | | | | | | | |
| | 11.1 Patient notes | | | | | | | | | | | |
| | 11.2 Medicine chart | | | | | | | | | | | |
| | 11.3 intake output chart | | | | | | | | | | | |

## CHECKLIST PROCEDURE 7: ADMINISTRATION INTRAVENOUS INFUSION MAGNESIUM SULPHATE (Mg SO4)

Nurse's name:……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 12. | Repeat Serum Magnesium blood test after 24 hours or as ordered. | | | | | | | | | | | |
| 13. | Notify Doctor of Magnesium Serum results. | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

FORMULA : __TOTAL_YES___ X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment :- .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature/Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 8: ADMINISTRATION INTRAVENOUS INFUSION LABETOLOL

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 8: ADMINISTRATION INTRAVENOUS INFUSION LABETOLOL

Nurse's name:……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | **PRE PROCEDURE** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** | |
| 1. | Receive written instructions from doctor | | | | | | | | | | | |
| 2. | Explain the procedure to patient. | | | | | | | | | | | |
| 3. | Ensure the branula size is either 16G or 18G is inserted | | | | | | | | | | | |
| | **INTRA PROCEDURE** | | | | | | | | | | | |
| 4. | Make sure it is the right patient. Ask for the patient's name and make sure it matches with the identification tag | | | | | | | | | | | |
| 5. | Follow 7 'R' | | | | | | | | | | | |
| 6. | Wash Hands | | | | | | | | | | | |
| 7. | Dilute medicine and label according to current protocol: for Loading or maintenance dose | | | | | | | | | | | |
| 8. | Check vital signs and records:<br>Every 15 minutes for loading dose until completed | | | | | | | | | | | |
| 9. | Check vital signs and records:<br>Every 30 minutes for maintenance dose until completed | | | | | | | | | | | |
| 10. | Observation of the fetal heart rate is done every 30 minutes and titrate according to doctor's order. | | | | | | | | | | | |
| | **POST PROCEDURE** | | | | | | | | | | | |
| 11. | Pay attention to abnormal signs such as: | | | | | | | | | | | |
| | 11.1 Headache and dizziness | | | | | | | | | | | |
| | 11.2 Low blood pressure | | | | | | | | | | | |
| | 11.3 Bradycardia | | | | | | | | | | | |
| 12. | Inform Doctor if any abnormalities | | | | | | | | | | | |
| 13. | Document in | | | | | | | | | | | |
| | 13.1 Patient notes | | | | | | | | | | | |
| | 13.2 Medication chart | | | | | | | | | | | |
| | 13.3 Intake output chart | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

## PROCEDURE 8 : ADMINISTRATION INTRAVENOUS INFUSION LABETOLOL

FORMULA : TOTAL YES X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment :- .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 9: ADMINISTRATION INTRAVENOUS INFUSION HYDRALAZINE

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1 | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

**CHECKLIST PROCEDURE 9: ADMINISTRATION INTRAVENOUS INFUSION HYDRALAZINE**

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | **PRE PROCEDURE** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** | **Y** | **N** | |
| 1. | Receive written instructions from doctor | | | | | | | | | | | |
| 2. | Explain the procedure to patient | | | | | | | | | | | |
| 3. | Make sure cannula site has no signs of phlebitis | | | | | | | | | | | |
| | **INTRA PROCEDURE** | | | | | | | | | | | |
| 4. | Wash hands | | | | | | | | | | | |
| 5. | Make sure it is the right patient. Ask for the patient's name and make sure it matches with the identification tag | | | | | | | | | | | |
| 6. | Follow 7 'R' | | | | | | | | | | | |
| 7. | Dilute the drug and label according to the current protocol: for loading dose or maintenance dose | | | | | | | | | | | |
| 8. | Check vital signs and records:<br>Every 15 minutes for loading dose | | | | | | | | | | | |
| 9. | Check vital signs:<br>Every 30 minutes for maintenance dose | | | | | | | | | | | |
| 10. | For pregnant mothers, observation of the fetal heart rate is done every 30 minutes. | | | | | | | | | | | |
| 11. | Inform Doctor if any abnormalities | | | | | | | | | | | |
| | **POST PROCEDURE** | | | | | | | | | | | |
| 12. | **Document in:** | | | | | | | | | | | |
| | 12.1 Patient notes | | | | | | | | | | | |
| | 12.2 Medicine chart | | | | | | | | | | | |
| | 12.3 Intake output chart | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

**PROSEDUR 9: ADMINISTRATION INTRAVENOUS INFUSION HYDRALAZINE**

FORMULA : $\frac{\text{TOTAL YES}}{\text{TOTAL PROCEDURE}}$ X 100%=

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment :- .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 10: ADMINISTRATION INTRAVENOUS INFUSION IRON THERAPY

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 10: ADMINISTRATION INTRAVENOUS INFUSION IRON THERAPY

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Receive written instruction from Doctor | | | | | | | | | | | |
| 2. | Greet mother & introduce yourself | | | | | | | | | | | |
| 3. | Explain the procedure to be carried out | | | | | | | | | | | |
| 4. | Check vital sign for baseline | | | | | | | | | | | |
| 5. | Prepare equipment as needed | | | | | | | | | | | |
| 6. | Wash hands | | | | | | | | | | | |
| 7. | Dilute medicine and label according to current protocol: for Loading or maintenance dose | | | | | | | | | | | |
| 8. | Ensure IV line is patent | | | | | | | | | | | |
| 9. | Check vital signs and records: Every 30 minutes for maintenance dose | | | | | | | | | | | |
| 10. | Ensure the infusion is completed within 4-6 hours | | | | | | | | | | | |
| 11. | For 1st time medication administration :<br>● Perform allergy test according to protocol<br>● Allow patient rest for 1 hour after allergy test<br>● Monitor vital sign and observe any allergic reaction | | | | | | | | | | | |
| 12. | Continuously monitor the patient's condition throughout the medication administration. | | | | | | | | | | | |
| 13. | Documentation | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

*according to facilities' protocol

## PROCEDURE 10: ADMINISTRATION INTRAVENOUS INFUSION IRON THERAPY

FORMULA : __TOTAL_YES__ X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment :- .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 11: HEEL DEXTROSTIC FOR NEWBORN BABY

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECK LIST PROCEDURE 11: HEEL DEXTROSTIX FOR NEWBORN BABY

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Greet the parents / guardian and inform the procedure | | | | | | | | | | | |
| 2. | Check the written instructions in the patient's record. | | | | | | | | | | | |
| 3. | Prepare the equipment | | | | | | | | | | | |
| 4. | Ensure the glucometer is calibrated. | | | | | | | | | | | |
| 5. | Wash hands | | | | | | | | | | | |
| 6. | Hold the baby's heel | | | | | | | | | | | |
| 7. | Gently massage the baby's heel to improve blood circulation | | | | | | | | | | | |
| 8. | Wipe the baby's heel with an alcohol swab and let it dry | | | | | | | | | | | |
| 9. | Puncture the baby's heel with the right technique and at lateral part of the heel | | | | | | | | | | | |
| 10. | Squeeze the baby's heel gently to draw blood | | | | | | | | | | | |
| 11. | Drop sufficient blood on the glucose strip | | | | | | | | | | | |
| 12. | Read, record and report results to the doctor | | | | | | | | | | | |
| 13. | Documentation | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

**PROCEDURE 11: HEEL DEXTROSTIC FOR NEWBORN BABY**

FORMULA : $\frac{\text{TOTAL YES}}{\text{TOTAL PROCEDURE}}$ X 100%=

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment: .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 12: HEEL TSB FOR NEWBORN BABY

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECK LIST PROSEDUR 12: *HEEL TSB FOR NEWBORN BABY*

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Greet the parents / guardian and inform the procedure | | | | | | | | | | | |
| 2. | Check the written instructions in the patient's record. | | | | | | | | | | | |
| 3. | Prepare the equipments | | | | | | | | | | | |
| 4. | Wash hands | | | | | | | | | | | |
| 5. | Hold the baby's heel | | | | | | | | | | | |
| 6. | Gently massage the baby's heel to improve blood circulation | | | | | | | | | | | |
| 7. | Wipe the baby's heel with an alcohol swab and let it dry | | | | | | | | | | | |
| 8. | Puncture the baby's heel with the right technique and at lateral part of the heel | | | | | | | | | | | |
| 9. | Squeeze the baby's heel gently to encourage the blood dripping | | | | | | | | | | | |
| 10. | Hold the capillary tube firmly to collect blood | | | | | | | | | | | |
| 11. | Send the specimen to laboratory | | | | | | | | | | | |
| 12. | Documentation | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

## PROSEDUR 12 : *HEEL TSB FOR NEWBORN BABY*

FORMULA : $\frac{\text{TOTAL YES}}{\text{TOTAL PROCEDURE}}$ X 100%=

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment :- .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature /Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 13: CARE OF BABY UNDER PHOTOTHERAPY

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 13: CARE OF BABY UNDER PHOTOTHERAPY

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Explain the purpose of phototherapy | | | | | | | | | | | |
| 2. | Check the phototherapy unit | | | | | | | | | | | |
| | 2.1 Cleanliness | | | | | | | | | | | |
| | 2.2 Bulbs | | | | | | | | | | | |
| | 2.3 Intensity of the irradiance | | | | | | | | | | | |
| | 2.4 Height from the baby's surface (40 – 45 cm) | | | | | | | | | | | |
| 3. | Prepare the baby | | | | | | | | | | | |
| | 3.1 Check baseline vital signs | | | | | | | | | | | |
| | 3.2 Cover the baby's eyes with sterile eye pad | | | | | | | | | | | |
| | 3.3 Remove the baby's clothing and protect the genitalia | | | | | | | | | | | |
| | 3.4 Place baby under phototherapy | | | | | | | | | | | |
| 4. | Change baby's position every 2 hours | | | | | | | | | | | |
| 5. | Encourage Mother To Fed Baby On Demand. | | | | | | | | | | | |
| 6. | Observe tolerance of feeding | | | | | | | | | | | |
| 7. | Observe for: | | | | | | | | | | | |
| | 7.1 Vital signs | | | | | | | | | | | |
| | 7.2 Colour | | | | | | | | | | | |
| | 7.3 Activities | | | | | | | | | | | |
| | 7.4 Cries | | | | | | | | | | | |
| | 7.5 Sepsis | | | | | | | | | | | |
| | 7.6 Condition of the skin | | | | | | | | | | | |
| | 7.7 Eliminations | | | | | | | | | | | |
| | 7.8 Side effects of phototherapy | | | | | | | | | | | |
| | 7.9 Early signs of kernicterus | | | | | | | | | | | |

## CHECKLIST PROCEDURE 13: CARE OF BABY UNDER PHOTOTHERAPY

Nurse's name: ……

Identification card no: ……..

Tick ( √ ) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 8. | Perform physical care: | | | | | | | | | | | |
| | 8.1 Top and tail | | | | | | | | | | | |
| | 8.2 Cord toilet | | | | | | | | | | | |
| | 8.3 Change linen | | | | | | | | | | | |
| 9. | Give physiological support to mother-maternal-infant-bonding | | | | | | | | | | | |
| 10. | Advise mother: | | | | | | | | | | | |
| | 10.1 Do not remove baby from the phototherapy unit too often | | | | | | | | | | | |
| | 10.2 Do not apply lotion or oil onto baby's skin | | | | | | | | | | | |
| | 10.3 Remove eye pad during feeding | | | | | | | | | | | |
| 11. | Assist doctor in blood investigations | | | | | | | | | | | |
| 12. | Report and record abnormalities if any | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

## PROCEDURE 13: CARE OF BABY UNDER PHOTOTHERAPY

FORMULA : __TOTAL_YES___ X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment: .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature/Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 14: TOP AND TAIL

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROCEDURE 14: TOP AND TAIL

Nurse's name: ……

Identification card no: ……..

Tick (√) in the correspond answer

| NO | ACTION | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | RN | | | | | | | | | | |
| | | | | | | | | | | | | |
| | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1. | Greet mother and introduce self | | | | | | | | | | | |
| 2. | Explain the purpose of the procedure | | | | | | | | | | | |
| 3. | Prepare the equipments and surrounding | | | | | | | | | | | |
| 4. | Wash hands | | | | | | | | | | | |
| 5. | Pour sterile water into gallipot with 6 balls of swabs | | | | | | | | | | | |
| 6. | Squeeze the swab and put inside the dry gallipot | | | | | | | | | | | |
| 7. | Clean both eyes from inside to outside with 2 swabs | | | | | | | | | | | |
| 8. | Clean the forehead from middle to the side of the eyes. | | | | | | | | | | | |
| 9. | From the side of the nose, clean both cheeks and drag behind the ears | | | | | | | | | | | |
| 10. | Dispose the swab into the clinical bin | | | | | | | | | | | |
| 11. | Clean from upper to lower nose and around the mouth | | | | | | | | | | | |
| 12. | Clean the chin with 1 swab | | | | | | | | | | | |
| 13. | Clean the buttocks | | | | | | | | | | | |
| 14. | Put on clothes | | | | | | | | | | | |
| 15. | Comfort the baby in the baby cot | | | | | | | | | | | |
| 16. | Clean and wash all equipments | | | | | | | | | | | |
| 17. | Inform doctor of abnormalities if any | | | | | | | | | | | |
| 18. | Documentation | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | |

**PROCEDURE 14: TOP AND TAIL**

FORMULA : __TOTAL_YES__ X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment :- .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature/Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 15: POSTNATAL CARE (MOTHER)

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROSEDURE 15: POSTNATAL CARE (MOTHER)

Nurse's name: ……

Identification no: ……

Tick (√) in the correspond answer

| NO | ACTION | | | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | RN | | | | | | | | | | |
| | | | | | | | | | | | | | | |
| | | | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1 | Greet mother and introduce self | | | | | | | | | | | | | |
| 2 | Advice mother to urinate prior to examination | | | | | | | | | | | | | |
| 3 | Do the evaluation and examination | | | | | | | | | | | | | |
| | 3.1 | Taking vital signs | | | | | | | | | | | | |
| | | 3.1.1 | Blood Pressure | | | | | | | | | | | |
| | | 3.1.2 | Body temperature | | | | | | | | | | | |
| | | 3.1.3 | Pulse Rate | | | | | | | | | | | |
| | | 3.1.4 | Respiration Rate | | | | | | | | | | | |
| | | 3.1.5 | Pain score | | | | | | | | | | | |
| | 3.2 | Breast examination to detect | | | | | | | | | | | | |
| | | 3.2.1 | • Breast Engorge<br>• *Nipple*<br>*-Crack*<br>*-inverted* | | | | | | | | | | | |
| | | 3.2.2 | Flow of Breastmilk | | | | | | | | | | | |
| | 3.3 | Measure the fundal height using measuring tape | | | | | | | | | | | | |
| | 3.4 | Wound Inspection<br>- Perineum / episiotomy<br>- LSCS incision | | | | | | | | | | | | |
| | | 3.4.1 | Cleanliness | | | | | | | | | | | |
| | | 3.4.2 | Signs of infection | | | | | | | | | | | |
| | | 3.4.3 | Oedema/haematoma | | | | | | | | | | | |
| | 3.5 | Examine the lochia by performing a vaginal examination and ask mother. | | | | | | | | | | | | |
| | | - Rubra 1-4 days | | | | | | | | | | | | |
| | | - Serosa 5-9 days | | | | | | | | | | | | |
| | | - Alba 10-15 days | | | | | | | | | | | | |
| | | -Odour | | | | | | | | | | | | |

CHECKLIST PROSEDURE 15: POSTNATAL CARE (MOTHER)

Nurse's name: ……

Identification no: ……

Tick (√) in the correspond answer

| NO | ACTION | | | ASSESSMENT RN P1 Y | P1 N | P2 Y | P2 N | P3 Y | P3 N | P4 Y | P4 N | P5 Y | P5 N | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 3.6 | Examine and evaluate signs and symptoms of DVT/Pulmonary Thromboembolism | | | | | | | | | | | | |
| | | 3.6.1 | Chest pain and difficulty in breathing | | | | | | | | | | | |
| | | 3.6.2 | Pain / swelling in both legs | | | | | | | | | | | |
| | | 3.6.3 | Redness/inflammation of lower limbs | | | | | | | | | | | |
| | | 3.6.4 | Calf tenderness | | | | | | | | | | | |
| 4 | **Signs of puerperal psychosis** | | | | | | | | | | | | | |
| | Enquire from mother / family members is there any emotional / behavioral changes; Through observation are there emotions and behavior that change or too much complaints, worries or unstable feelings | | | | | | | | | | | | | |
| 5 | **Health Education** | | | | | | | | | | | | | |
| | 5.1 | Postnatal nutrition | | | | | | | | | | | | |
| | 5.2 | Breast care / breastfeeding | | | | | | | | | | | | |
| | 5.3 | Personal hygiene/Episiotomy wound care / LSCS wound | | | | | | | | | | | | |
| | 5.4 | Family Planning | | | | | | | | | | | | |
| | 5.5 | Postnatal exercise | | | | | | | | | | | | |
| 6 | Refer to Medical Officer if necessary | | | | | | | | | | | | | |
| 7 | **Documentation:** | | | | | | | | | | | | | |
| | 7.1 | - KIK /1(a)/96 (Pind. 2020)<br>- KIK /1(b)/96 (Pind. 2020)<br>- Senarai Semak Pengendalian Postnatal | | | | | | | | | | | | |
| | 7.2 | Buku rekod KIB 101 / terkini / (ikut cara dokumentasi fasiliti) | | | | | | | | | | | | |
| | 7.3 | Buku rekod KIB 105 / terkini | | | | | | | | | | | | |
| | | | TOTAL | | | | | | | | | | | |

**PROSEDURE 15: POSTNATAL CARE (MOTHER)**

FORMULA : __TOTAL_YES__ X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment: .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature/Official Stamp | | | | | |
| Date assessment | | | | | |

## PROCEDURE 16: POSTNATAL CARE (BABY)

| No | Date | RN | Assessment | Assessor's Name & Sign | Remarks |
|---|---|---|---|---|---|
| 1. | | | Observe | | |
| 2. | | | Observe | | |
| 3. | | | Observe | | |
| 1. | | | Assist | | |
| 2. | | | Assist | | |
| 3. | | | Assist | | |
| 1. | | | Perform | | Competent/ Not Competent |
| 2. | | | Perform | | Competent/ Not Competent |
| 3. | | | Perform | | Competent/ Not Competent |
| 4. | | | Perform | | Competent/ Not Competent |
| 5. | | | Perform | | Competent/ Not Competent |

## CHECKLIST PROSEDURE 16: POSTNATAL CARE (BABY)

Nurse's name: ……

Identification no: ……

Tick ( √ ) in the correspond answer

| NO | ACTION | | ASSESSMENT | | | | | | | | | | REMARKS |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | RN | | | | | | | | | | |
| | | | | | | | | | | | | | |
| | | | P1 | | P2 | | P3 | | P4 | | P5 | | |
| | | | Y | N | Y | N | Y | N | Y | N | Y | N | |
| 1 | Enquire the mother / guardian about the condition of baby | | | | | | | | | | | | |
| 2 | **Perform evaluation and examination** | | | | | | | | | | | | |
| | 2.1 | Physical examination | | | | | | | | | | | |
| | 2.2 | Body Temperature | | | | | | | | | | | |
| | 2.3 | Assess the level of Jaundice<br>- Perform blanching test for 10 seconds | | | | | | | | | | | |
| | 2.4 | Examination of umbilical cord | | | | | | | | | | | |
| 3 | **Provide Health Education / Advice (if necessary)** | | | | | | | | | | | | |
| | 3.1 | Breast feeding | | | | | | | | | | | |
| | 3.2 | Umbilical Cord Care | | | | | | | | | | | |
| | 3.3 | Management of Jaundice | | | | | | | | | | | |
| | 3.4 | Give feedback on the baby's condition at the end of the session | | | | | | | | | | | |
| 4 | **Documentation** | | | | | | | | | | | | |
| | 4.1 | KIK /1(a)/96 (Pind. 2020)<br>KIK /1(b)/96 (Pind. 2020)<br>Buku Rekod Kesihatan Bayi dan Kanak-kanak (0-6 tahun) | | | | | | | | | | | |
| | 4.2 | Buku rekod KIB 101 / terkini | | | | | | | | | | | |
| | 4.3 | Buku rekod KIB 102 / terkini | | | | | | | | | | | |
| | 4.4 | Buku rekod KIB 103 / terkini | | | | | | | | | | | |
| | 4.5 | Buku rekod KIB 105 / terkini | | | | | | | | | | | |
| | TOTAL | | | | | | | | | | | | |

**PROSEDURE 16: POSTNATAL CARE (BABY)**

FORMULA : TOTAL YES X 100%=
TOTAL PROCEDURE

| COMPETENT | NOT COMPETENT |
|---|---|
| >80% | < 80% |
| | |

Comment :- .....

.....

.....

| TITLE | ASSESSMENT | | | | |
|---|---|---|---|---|---|
| | 1 | 2 | 3 | 4 | 5 |
| Assessor's name | | | | | |
| Position | | | | | |
| Signature/Official Stamp | | | | | |
| Date assessment | | | | | |

**Verification**

This logbook has been assessed and found completed

| O&G Nursing Supervisor | O&G Specialist |
| --- | --- |
| Name: | Name: |
| Official Stamp | Official Stamp |