

Care at Admission to Delivery Checklist

Health Facility Name:..... Supervisor name:

Date: / / Supervisee name:.....

MD 3	The following items represent standard practices at the admission of the woman to the delivery room according to protocols/ guidelines	Observation
1	Lady is warmly welcomed.	<input type="checkbox"/> Y <input type="checkbox"/> N
2	Current obstetric history is taken (gestational age, reason for attendance, fetal movement, labor pain, duration and intensity, passage of any fluids through the vagina, any events or complications throughout the course of this pregnancy, availability of any referral notes).	<input type="checkbox"/> Y <input type="checkbox"/> N
3	Past obstetric history is taken (gravity, parity, duration of previous pregnancies, mode of previous deliveries, birth weight of all previous births, any previous complications during or adverse outcome of previous pregnancies and/or deliveries).	<input type="checkbox"/> Y <input type="checkbox"/> N
4	History taking (Complete medical and family history).	<input type="checkbox"/> Y <input type="checkbox"/> N
5	Vital signs are taken (BP, Pulse and Temperature).	<input type="checkbox"/> Y <input type="checkbox"/> N
6	General physical examination is performed including height measurement and examination of (chest, heart, abdomen and lower limbs for edema and varicose veins).	<input type="checkbox"/> Y <input type="checkbox"/> N
7	Fetal heart is assessed for at least 5 minutes.	<input type="checkbox"/> Y <input type="checkbox"/> N
8	Obstetric exam of abdomen is properly performed; palpation of abdomen to determine height of fundus, lie, attitude and presenting part with level of engagement.	<input type="checkbox"/> Y <input type="checkbox"/> N
9	Obstetric exam of pelvis is properly performed using lubricants to determine dilatation, length, position and consistency of the cervix; and the condition of the membranes, whether intact or ruptured and the color of amniotic fluid if applicable; the presenting part, station of descends and any molding or caput should also be determined.	<input type="checkbox"/> Y <input type="checkbox"/> N
10	Detailed history and all assessment findings and plan of care are documented completely, properly and accurately and signed.	<input type="checkbox"/> Y <input type="checkbox"/> N
11	Lab tests: BG & Rh, CBC, urine analysis were conducted.	<input type="checkbox"/> Y <input type="checkbox"/> N
12	Woman is offered a shower and given a clean gown to wear.	<input type="checkbox"/> Y <input type="checkbox"/> N
13	If cervix is 4 cm or more dilated findings are entered to the partograph in a complete and accurate manner.	<input type="checkbox"/> Y <input type="checkbox"/> N
14	Throughout assessment, audio and visual privacy is provided and prior to each exam/procedure woman is explained why and how it is performed and she is asked for permission.	<input type="checkbox"/> Y <input type="checkbox"/> N
15	Woman and her accompanists are fully informed about, the findings and the plan of management.	<input type="checkbox"/> Y <input type="checkbox"/> N

*** Please document the key observations on practices in the supervisory report form with in depth analysis whenever needed and suggestions for solutions and next steps**