Basic Nursing Procedure Manual
Maternal Health Nursing/Clinical

Antenatal Performance
Lippincott-Checklist

Grades shall be assigned to individual students on the basis of the instructor's judgment of the student's scholastic achievement using the grading system below

Excellent - Exceptional Achievement	**4**	**A**
Very Good - Extensive Achievement	**3**	**B**
Good - Acceptable Achievement	**2**	**C**
Fair- Minimal Achievement	**1**	**D**
Poor - Inadequate Achievement (***To secure credit, course must be repeated.)***	**0**	**F**

Antenatal Performance Checklist

Student Name: …….. Date: ……..
Instructor: …… Clinical Area: ……..

Preparations	0	1	2	3	4
• Prepare the client care area, necessary supplies, and equipment.					
• Use an antiseptic hand rub or wash hands thoroughly with soap and water and dry with clean, dry cloth or allow to air dry.					
• Greet the woman and her companion respectfully and with kindness, introduce yourself, and offer the woman a seat.					
• Tell the woman what you are going to do, encourage her to ask questions, and listen to what she has to say.					
Obtain comprehensive History: (First Visit)					
• Personal History • Medical & Surgical History • Menstrual& Obstetric History • Present Pregnancy • Daily Habits and Lifestyle					
Physical Examination: **Assessment of General Well-Being and Blood Pressure, Weight (Every Visit)**					
1. Observe her general well-being: • Her gait and movements (walks steadily) • Her facial expression (is alert and responsive) • Her general cleanliness (no visible dirt, no odor) • Her skin (free from lesions and bruises) • Her conjunctiva (are pink, not white or very pale pink in color)					
2. Measure blood pressure • If diastolic BP is >90 mm Hg., ask the woman if she has severe headache, blurred vision or epigastric pain, and check her urine for protein					
Preparing for Further Examination					
3.Explain the steps in the physical examination and obtain the woman's consent.					
4. Ask her to empty her bladder. Have her provide a urine sample if indicated and if urine testing is available.					
5. Have the woman undress in private. Ask her to remove only enough clothing to complete the examination.					
6. Provide her with a drape or cloth to cover the parts of her body that are not being examined.					

7. Help her onto the examination surface and assist her in assuming a comfortable position.					
Visual Breast Examination (First Visit/As Needed)					
8. Conduct **visual breast examination (First visit/as needed)**: • Ask the woman to sit on the examination surface, uncover her body from the waist up, and place her arms at her sides. • Visually inspect the overall appearance of the woman's breasts (contours, skin, nipples and note any abnormalities)					
Abdominal Examination (Every Visit)					
9. Ask the woman to lie on her back with her knees slightly bent and uncover her abdomen.					
10. Check abdomen for scars, Linea nigra, stria gravidarum, umbilical Herniation • If there is a scar, ask if it is from a caesarean section or other uterine surgery					
11. Measure fundal height: • If 12–22 weeks, palpate and estimate weeks of gestation by determining distance between top of Fundus and symphysis pubis. • If more than 22 weeks, use a tape measure to determine the number of centimeters from the upper edge of symphysis pubis to the top of the Fundus.					
12. Carry out **fundal palpation:** • Stand at the woman's side, facing her head. • Place both hands on the sides of the Fundus at the top of the abdomen to assess **fetal lie and presentation.** • Using the flat part of your fingers, apply gentle but firm pressure to assess consistency and mobility of the fetal part.					
13. Carry out **lateral palpation:** • Move hands smoothly down sides of uterus to feel for fetal back. • Keep dominant hand steady against the side of uterus, while using palm of other hand to apply gentle but deep pressure to explore opposite side of uterus. • Repeat procedure on other side of uterus.					
14. Carry out **Pawlik's palpation:** •Place hand on the lower part of the abdomen to assess engagement of the presenting part					
15. Carry out **supra-pubic (pelvic) palpation:** • Turn and face the woman's feet. • Place hands on either side of uterus with palms below the level of the umbilicus and fingers pointing to symphysis pubis to assess fetal position. • Grasp fetal part snugly between hands to feel shape, size, consistency and mobility.					

• Observe the woman's face for signs of pain/tenderness during palpation.					
16. Listen to the **fetal heart rate:** • Place fetal stethoscope on abdomen (on the same side that you palpated the fetal back. • Place your ear in close, firm contact with fetal stethoscope. • Remove hands from fetal stethoscope and listen to fetal heart for a full minute, counting beats against the second hand of a clock. • Feel the woman's pulse at wrist, to ensure that fetal heart tones, and not maternal pulse, are being measured.					
17. Remove gloves by turning them inside out: If disposing of gloves, place in leak proof container or plastic bag					
18. Use antiseptic hand rub or wash hands thoroughly with soap and water and dry with clean, dry cloth or allow to air dry.					
19. Help the woman off the examination table.					
20. Share your findings with the woman.					
21.Document Findings					