

STRUCTURED OBSERVATIONAL CHECKLIST

SECTION A: HEALTHCARE PROVIDER BACKGROUND (THIS SECTION REFERS TO THE HEALTHCARE PROVIDER WHO PERFORMED THE NEWBORN RESUSCITATION).

(Please respond by ticking in the box next to the answer most suitable for you)

PARTICIPANT CODE: _____

DATE: _____

BIODATA

1. YOUR AGE (YEARS): _____

2. GENDER:

MALE	<input type="checkbox"/>	FEMALE	<input type="checkbox"/>
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TRAINING AND QUALIFICATION

3. **HEALTH PROVIDER LEVEL**

1	Specialist (Obs/Gyn)	<input type="checkbox"/>
2	Medical Officer	<input type="checkbox"/>
3	Nursing Officer/Midwife	<input type="checkbox"/>
4	Clinical Officer	<input type="checkbox"/>
5	Other	<input type="checkbox"/>

4. **HIGHEST QUALIFICATION ACHIEVED HEALTH PROVIDER LEVEL OF TRAINING**

1	Master's Degree	<input type="checkbox"/>
2	Bachelor's Degree	<input type="checkbox"/>
3	Diploma	<input type="checkbox"/>
4	Certificate	<input type="checkbox"/>
5	Other	<input type="checkbox"/>

5. **HAVE YOU EVER ATTENDED A NEONATAL RESUSCITATION TRAINING?**

YES..... (PROCEED TO QUESTION 6)

NO..... (PROCEED TO QUESTION 8)

6. **PRIOR NR TRAINING ATTENDED (TICK ALL THAT APPLY)**

1	Helping Babies Breath (HBB)	<input type="checkbox"/>
2	Pediatric Advanced Life Support (PALS)	<input type="checkbox"/>
3	Emergency Triage Assessment and Treatment (ETAT/ETAT +)	<input type="checkbox"/>
4	European Pediatric Life Support (EPLS)	<input type="checkbox"/>
5	Other (please specify)	<input type="checkbox"/>

7. **DURATION (MONTHS/YEARS) SINCE LAST NR TRAINING (INCLUDE FOR ALL TRAININGS ATTENDED)**

YEARS.....MONTHS.....

SUPERVISION AND EXPERIENCE

8. **HAVE YOU EVER HAD SUPPORT SUPERVISION IN NR IN THE WARD?**
 YES (PROCEED TO QUESTION 9)
 NO..... (PROCEED TO QUESTION 11)

9. **TIME SINCE MOST RECENT STAFF SUPERVISION**

1	< 6 months	
2	6 - 12 months	
3	> 12 months	

10. **WHO DID THE SUPERVISION?**

1	WARD IN – CHARGE	
2	UNIT MANAGER	
3	PUBLIC HEALTH NURSE	
4	WARD MATE/COLLEAGUE	

11. **DURATION OF PRACTICE IN MATERNITY UNIT (MONTHS/YEARS):**

YEARS.....MONTHS.....

SECTION B: CLINICAL PROTOCOLS AND GUIDELINES (Tick where applicable)

This section to be completed by the principal researcher or research assistant

	JOB AIDS	YES	NO	REMARKS
1	Are visual NR action plans/guidelines present at the resuscitation areas?			
2	Do the healthcare workers refer to the NR guidelines/action plans during resuscitation?			
3	Are there flip charts for on job resuscitation training among healthcare providers in the labor unit?			

SECTION C: BASIC NEONATAL RESUSCITATION EQUIPMENT CHECKLIST

(To be filled in at the start of each resuscitation by the principal researcher or research assistant)

Instructions: Please tick in appropriate column to indicate if equipment is present or absent. The percentages will be calculated later.

STATION: **LABOR WARD** ____ **MATERNITY THEATRE** ____ **NEWBORN UNIT** ____

PERMANENT ITEM	PRESENT	ABSENT	IN WORKING CONDITION
Warmer/ resuscitaire			
Oxygen source			
Suction machine			
Ambu bag (500mls)			
Clock			

TEMPORARY ITEM	PRESENT	ABSENT	REMARKS
Suction tube (6F,8F and 10F)			
Bulb suction device (penguin device, coloured bulb sucker)			
Face mask (preterm: size 0; term: size 1)			
Mode of oxygen delivery (nasal catheter, nasal prongs, face mask)			
Oxygen tubing			
Clean dry towels (2)			

SECTION D: NEWBORN RESUSCITATION OBSERVATION CHECKLIST

Instructions: Please tick to the choice that applies to resuscitation being observed

NO. OF OBSERVATIONS: /5 DATE.....

SHIFT: DAY..... EVENING..... ... NIGHT.....

STATION: LABOR WARD.....MATERNITY THEATRE.....NEWBORN UNIT.....

RESUSCITATION PROCEDURE (please tick yes/ no depending on observation made during resuscitation)

PARAMETER	OBSERVATION	YES	NO
PREPARATION FOR NEWBORN RESUSCITATION			
A. PREPARATION FOR RESUSCITATION	1. Prepares area for resuscitation		
	2. Checked availability of resuscitation equipment		
	3. Check equipment: Ventilation bag, Full term mask, Preterm mask, Suction bulb, Warmth (warmer/clothing).		
	4. Identify a helper		
Remarks			
IMMEDIATELY AT BIRTH (FOR NEWBORN WHO DID NOT BREATHE AT BIRTH)			
B. DRYING/ STIMULATING	1. Was the baby dried thoroughly? (by gently rubbing the back)		
	2. Was the wet cloth removed?		
	3. Was the baby kept warm?		
	Did the baby respond after drying/stimulating?		
	OUTCOME		
REMARKS			
IF BABY NOT BREATHING AND/OR CRYING AFTER DRYING AND STIMULATION			
C. CHECK/OPEN AIRWAY	1. Looked into airway?		
	a. *Was meconium present?		
	b. If yes, was suctioning of airway done before drying/stimulating?		

	*Was the child breathing before suctioning?		
	2. Was the baby's airway cleared with a suction bulb if unresponsive?		
	3. Was the baby's head positioned in a neutral position?		
	*Did the baby respond after clearing the airway?		
	OUTCOME		
	REMARKS		
IF BABY DOES NOT RESPOND TO INITIAL RESUSCITATION EFFORTS (POOR OR NO BREATHING/GASPING)			
D. BAG AND MASK VENTILATION	1. Was bag – and – mask ventilation (BMV) initiated?		
	*Time BMV initiated after birth (seconds)		
	2. Was BMV initiated within the Golden minute (60s)?		
	*Did the baby respond after this initial BMV?		
	IF BABY DID NOT RESPOND AFTER THE INITIAL BMV (ADVANCED BMV)		
	1. Did the healthcare provider call for help?		
	2. Was the correct mask size used during BMV? (Covers nose, mouth and makes a tight seal)		
	3. Were there chest movements with each ventilation?		
	4. Was the ventilation rate within 30 – 50 per minute?		
	5. Was the baby's heart rate checked at 1 min?		
	Did BMV continue if baby still unresponsive?		
	*Did the baby respond after this assisted BMV?		
	OUTCOME		
REMARKS			
IF POOR OR NO BREATHING/GASPING AFTER BMV			
E. SUPPORT VENTILATION (IMPROVE	1. Was 1 effective breath for every 3 compressions for 1 min done?		
	2. Did the baby require support breathing (supportive oxygen)?		

VENTILATION)	*Did the baby respond after the support ventilation?		
	OUTCOME		
	REMARKS		

NAME OF OBSERVER:

SECTION E: NEONATAL PROGRESS MONITORING AND OUTCOME FORM

Gestational Age (weeks):.....Birth weight (grams):.....

Mode of delivery: SVD Assisted delivery Caesarean section Breech

	OUTCOME	PARAMETER	YES	NO
	AT 1 MIN APGAR SCORE.....	Did The Baby Cry/Breathe After Drying/Stimulating at 1 Min?		
		Did The Baby Respond To Clearing Of Airway?		
		Others (specify)		
	AT 5 MIN APGAR SCORE.....	A - Skin color pink?		
		G- Crying or active withdrawal?		
		A-Active motion?		
		R- Good cry?		
		Others (specify)		
	AT 10 MIN APGAR SCORE.....	A - Skin color pink?		
		G- Crying or active withdrawal?		
		A-Active motion?		
		R- Good cry?		
		Others (specify)		
	AT 1 HOUR	Baby breathing well with mother		

		Baby alive on oxygen therapy		
		Baby alive in special care area/unit		
		Others (specify)		

SECTION F: INFECTION PREVENTION PRACTICES

To be completed after completion of NR procedure by the principal researcher or research assistant.

	TASK	YES	NO
1	CLEANING: Ventilation bag and mask device disassembled (suction device if possible) while still wearing gloves.		
2	DECONTAMINATION: all parts soaked in a 0.5% chlorine solution for 10 minutes.		
3	All parts washed with soap and water and rinsed carefully with clean water to remove all soap.		
4	HLD: Parts boiled in water for 10 – 20 minutes OR soak in activated glutaraldehyde/cidex solution, then rinsed well with boiled water OR steam autoclave.		
5	Dry completely and keep clean until next use		
6	REMARKS		