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# MBBS Practical Notes

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# Antenatal History Gestational Age and EDD

Practical 01 / Supervised clinical examination

## Aim

Record an obstetric history, calculate gestational age and perform an external antenatal assessment.

## Principle

Reliable last menstrual period dates and early dating scans inform gestational age. Abdominal findings and antenatal records help assess pregnancy progress.

## Materials and Requirements

- Antenatal record and calendar
- Obstetric model or examination couch, non-stretch tape and teaching fetal heart device

## Procedure

1. Confirm identification, consent, comfort and current symptoms. Ask the first day of the last menstrual period, cycle regularity and available dating scan.
2. Explain the external examination and provide privacy and comfortable support. Ask about bleeding, pain or other immediate concerns and clarify exact menstrual and scan dates.
3. Record previous pregnancies and their outcomes. Count the current pregnancy in gravidity and record parity using the institution's notation.
4. Record the current and prior pregnancies separately, including gestation, mode of birth and material complications. Check how the institution defines and writes parity and whether information is incomplete.
5. Count elapsed days from the first day of a reliable last menstrual period. Convert to completed weeks and remaining days. For a regular 28-day cycle, add 280 days to that menstrual date for the estimated due date.

Continue with step 6 on the next page.

# Procedure Continued

Antenatal History Gestational Age and EDD

6. Write the assessment and dating dates, calculate elapsed days and divide by seven for weeks and remaining days. Compare the calculated due date with the clinician-approved dating record.
7. On an abdominal model or with supervision, inspect, measure symphysis–fundal height at the relevant gestation and assess lie and presentation when appropriate. Listen for fetal heart activity as taught.
8. On the abdominal trainer identify the symphysis pubis and uterine fundus and measure along the uterine longitudinal axis as taught. Use the case gestation to decide when lie and presenting part can be assessed.
9. Review blood pressure and antenatal results and summarise gestation, pregnancy history, findings and next assessment.
10. Check the antenatal record, relevant vital signs and fetal assessment supplied. Present dating basis, obstetric formula, significant findings and question for follow-up with the supervising team.

## Precautions

- Explain each step and preserve comfort and privacy. This station uses external examination.
- Report significant bleeding, severe symptoms or concern about fetal wellbeing promptly.

# Observations and Interpretation

Antenatal History Gestational Age and EDD

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Dating | Menstrual date, scan and elapsed weeks plus days | Supports reliable gestational age |
| Obstetric history | Pregnancies, births and outcomes | Identifies risks relevant to the current pregnancy |
| External examination | Fundal height, lie, presentation and documented fetal assessment | Adds clinical context |

### Worked Example

The reliable menstrual date is 1 January 2026. At the 21 May visit 140 days have elapsed, giving 20 weeks and 0 days. Adding 280 days gives an estimated due date of 8 October 2026.

## Result and Interpretation

Document the calculated dates and compare with the clinical dating record. If menstrual dating is uncertain, use the clinician-confirmed dating assessment.

## Viva Questions and Answers

### What is gravidity?

The total number of pregnancies including the current pregnancy.

### When is menstrual dating less reliable?

When the date is uncertain, cycles were irregular or an early scan materially disagrees.

# Antenatal Risk and Obstetric Triage

Practical 02 / Clinical or documentation case

## Aim

Recognise urgent findings in an antenatal encounter and prioritise assessment and handover.

## Principle

Bleeding, severe hypertension symptoms, reduced fetal movements and physiological instability require prompt assessment. Gestation and history guide the differential.

## Materials and Requirements

- Fictional antenatal card and trend chart, BP cuff and case cards
- Maternity escalation and referral checklist

## Procedure

1. Confirm gestation, symptom onset, previous complications and current medicines. Ask about bleeding, pain, headache, visual symptoms and fetal movements as appropriate.
2. Establish gestation, recent course, previous obstetric complications and medicines. Ask about symptom timing and directed warning features while arranging help for an urgent concern.
3. Assess stability and check blood pressure using an appropriate cuff. Record maternal vital signs and obtain help for abnormal findings.
4. Use the correct cuff on the supported arm and record blood pressure with time. Also check pulse, breathing, perfusion and alertness as appropriate. Escalate severe symptoms or observations immediately.

Continue with step 5 on the next page.

# Procedure Continued

Antenatal Risk and Obstetric Triage

5. Review antenatal results and risks for hypertension, haemorrhage, anaemia, diabetes or infection. Identify maternal and fetal assessments needed.
6. Compare current findings with antenatal trends and case risk factors. Determine what fetal assessment or maternal investigation the responsible team needs next and which review can wait.
7. Choose the immediate escalation tier and prepare the referral information. Identify investigations likely to affect the next decision.
8. Prepare a focused urgent referral including gestation, symptoms, current and prior observations, interventions and outstanding findings. Confirm that the receiving service knows the priority.
9. Explain the reason for urgent assessment in clear terms and document who received the handover.
10. Explain why further assessment is needed and where it will occur. Document handover time, team and planned monitoring or transport arrangements.

## Precautions

- Escalate urgently before completing routine examination.
- For antepartum bleeding, defer a digital vaginal examination until the obstetric team has excluded placenta praevia or other contraindications.

# Observations and Interpretation

Antenatal Risk and Obstetric Triage

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Symptoms | Gestation, onset and maternal or fetal concerns | Narrows urgent possibilities |
| Maternal status | Vital-sign trends and associated findings | Identifies instability |
| Handover | Reason, urgency and destination | Supports continuity of care |

### Worked Example

At 32 weeks a patient has blood pressure 166/112 mmHg, new severe headache and visual symptoms. The case record shows previously normal pressures.

## Result and Interpretation

The combination requires immediate maternity team assessment for a severe hypertensive disorder. Communicate values, symptoms, pregnancy dates and time of review.

## Viva Questions and Answers

### Why ask about visual symptoms with high blood pressure?

They may accompany a severe hypertensive disorder of pregnancy.

### Why document the measurement time and cuff?

They make the reading traceable and help interpret changes.

# Labour Monitoring and Assisted Observation of Normal Birth

Practical 03 / Skills laboratory simulation

## Aim

Chart labour observations and demonstrate the student's role in a normal birth simulation.

## Principle

Labour care tracks maternal and fetal wellbeing and progress together. The chart supports timely review of deviations and communication across shifts.

## Materials and Requirements

- Birth model, birth record and current Labour Care Guide or facility chart
- Time-stamped maternal, fetal and labour observations

## Procedure

1. Verify identity and pregnancy details, review risk factors and discuss comfort, preferences and consent. Define the student and supervisor roles.
2. Review labour stage, risks and preferences. With the WHO Labour Care Guide, start charting the active first stage when dilatation reaches 5 cm or more in established active labour. Confirm the applicable chart and the team's monitoring roles.
3. Enter contractions, cervical findings supplied by faculty, maternal observations and fetal heart information by time. Document membranes and fluid when relevant.
4. Enter each maternal and fetal observation beside its actual time. Record contractions, membrane status, fluid and exam findings supplied by the instructor without inventing unavailable entries.

Continue with step 5 on the next page.

# Procedure Continued

Labour Monitoring and Assisted Observation of Normal Birth

5. Identify chart alerts and inconsistent trends. Call the supervising clinician and record the response.
6. Review the trajectory and the applicable chart thresholds and mark concerning values. Call the responsible clinician and record the response and reassessment time.
7. On the model, prepare the station and demonstrate the assigned observation or assistance sequence under faculty direction. Include immediate newborn readiness and active communication.
8. On the birth trainer review the team's equipment, infection prevention and maternal communication checks. Observe and perform the assigned assistance tasks with faculty and prepare for simulated immediate newborn assessment.
9. Record time of birth, maternal observations, blood loss, placenta assessment and neonatal status using the simulation case.
10. Complete the birth entry with times, newborn condition, maternal findings, placental review and cumulative measured loss. Confirm the next postpartum observation and team handover.

## Precautions

- Observe or assist only within the student role with consent and supervision.
- Use current facility alerts and avoid applying a universal dilation rate to all labours.

# Observations and Interpretation

Labour Monitoring and Assisted Observation of Normal Birth

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Maternal observations | Vital signs, symptoms and support needs | Assesses maternal wellbeing |
| Fetal and labour findings | Fetal heart trend, contractions, progress and membranes | Supports timely review |
| Birth summary | Time, early findings and escalation | Enables team follow-up |

### Worked Example

The model case shows documented cervical progress but two concerning fetal heart observations. The student calls for review before continuing routine charting.

## Result and Interpretation

Fetal and maternal status take priority. Chart the findings and the action required by the facility pathway.

## Viva Questions and Answers

### Why plot exact observation times?

They make changes and their relation to actions clear.

### What is the student role when a new alert appears?

Call the responsible team and communicate the trend clearly.

# Postpartum Haemorrhage Recognition and Skills Stations

Practical 04 / Skills laboratory simulation

## Aim

Recognise postpartum haemorrhage and demonstrate the assigned response techniques on trainers.

## Principle

Early escalation, quantified blood loss, maternal status and identification of the cause guide the emergency response. Tone, trauma, tissue and thrombin organise the differential.

## Materials and Requirements

- Postpartum manikin, graduated collection drape and vital-sign chart
- Trainer balloon, non-pneumatic anti-shock garment and skills checklists

## Procedure

1. Recognise heavy or ongoing bleeding and abnormal vital signs. Call the obstetric haemorrhage response and allocate team roles.
2. In the WHO-based vaginal birth case, activate the response for measured loss of at least 500 mL, or at least 300 mL with an abnormal circulatory sign such as systolic blood pressure below 100 mmHg. Escalate brisk bleeding or instability immediately at any volume.
3. Read the calibrated collection device, document cumulative loss and assess the simulated uterine tone and maternal status.
4. Add each measured volume to the running total and record time, pulse, blood pressure, perfusion and simulated uterine tone. Report deteriorating observations while measurement continues.

Continue with step 5 on the next page.

# Procedure Continued

Postpartum Haemorrhage Recognition and Skills Stations

5. Review the four causes. State the relevant facility actions for resuscitation and source control with the supervisor.
6. Rehearse the team's first-response bundle with faculty. Assign uterine massage, a uterotonic, tranexamic acid, IV fluids, examination to identify the bleeding source and escalation of care. Use the scenario findings to assess tone, trauma, retained tissue and coagulation.
7. At instructor-led model stations show indications and positioning for bimanual and aortic compression, balloon tamponade and the anti-shock garment. Use the device and local checklists.
8. At each teaching model identify indication, required preparation and point of escalation. Demonstrate the assigned manoeuvre or device using its checklist and verify the instructor's model result.
9. Reassess loss, uterine findings and perfusion and communicate time, response and transfer or definitive care needs.
10. Re-evaluate bleeding, tone and perfusion after each simulated action. Give a handover with total loss, response, outstanding concern and the team responsible for definitive care.

## Precautions

- Perform hands-on haemorrhage techniques only on trainers for this station.
- Use full clinical escalation for continued bleeding or instability.

# Observations and Interpretation

Postpartum Haemorrhage Recognition and Skills Stations

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Loss and time | Cumulative measured volume, pace and interventions | Quantifies ongoing bleeding |
| Probable cause | Tone, trauma, tissue and coagulation concerns | Guides focused assessment |
| Response | Vital signs, technique and reassessment | Supports escalation |

### Worked Example

After a simulated vaginal birth, record 350 mL of blood loss and a systolic blood pressure of 86 mmHg. Bleeding continues and the uterus feels soft on the model.

## Result and Interpretation

Activate the haemorrhage response immediately. The measured loss and low blood pressure meet the early response criteria. Assess for uterine atony and help the team reassess bleeding and perfusion.

## Viva Questions and Answers

### What are the four Ts?

Tone, trauma, tissue and thrombin.

### Why record blood loss cumulatively?

Repeated amounts can add up quickly and change the team's assessment.

# Postpartum Review and Contraception Counselling

Practical 05 / Communication role-play

## Aim

Assess postpartum concerns and use shared decision-making to discuss contraception and puerperal sterilisation.

## Principle

Postpartum options depend on timing, breastfeeding, medical eligibility and personal preferences. Permanent contraception requires informed and voluntary decision-making.

## Materials and Requirements

- Fictional postpartum record, method display and eligibility guide
- Counselling and follow-up form

## Procedure

1. Ask about wellbeing, bleeding, pain, feeding, recovery and the person's pregnancy-spacing preferences. Identify urgent symptoms first.
2. Check postpartum timing, bleeding, pain, fever, feeding and wellbeing, then discuss spacing preferences privately. Escalate concerning physical or mental symptoms before routine counselling.
3. Explain the practical differences between relevant temporary and permanent options, including effectiveness, reversibility, side effects and availability.
4. Ask which qualities matter most, including reversibility, convenience and access. Compare suitable methods in a balanced way, explaining how each is used and common practical concerns.

Continue with step 5 on the next page.

# Procedure Continued

Postpartum Review and Contraception Counselling

5. Review breastfeeding, postpartum timing and clinical eligibility using the local guide. Discuss STI prevention where relevant.
6. Use the current local medical eligibility guide with pregnancy timing, breastfeeding and the clinical risks in the case. Verify eligibility and access with the clinician before recording a proposed choice.
7. Explain permanency, potential failure, alternatives and consent requirements for sterilisation. Give time for questions and avoid pressure.
8. Discuss permanent contraception only with informed voluntary consent. Explain intended permanence, possible failure and alternatives, and allow time for questions or deferral.
9. Ask for teach-back and record the patient's choice, uncertainty or request for another discussion. Agree on next contact.
10. Ask the person to explain their choice or undecided options and the next visit. Record an agreed plan for obtaining the method, follow-up, warning symptoms and any outstanding decision.

## Precautions

- Respect voluntary choice and confidentiality. Use an interpreter when needed and chosen by the patient.
- Urgently refer concerning postpartum symptoms.

# Observations and Interpretation

Postpartum Review and Contraception Counselling

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Postpartum status | Recovery symptoms, feeding and timing | Identifies review and eligibility needs |
| Preferences | Spacing goals and option priorities | Supports informed choice |
| Agreement | Decision, follow-up and pending questions | Records a voluntary plan |

### Worked Example

A breastfeeding patient wants spacing and asks about permanent contraception but is unsure. The student discusses reversible alternatives and agrees on a follow-up visit.

## Result and Interpretation

Document the preference and allow time for the person to consider options. Confirm eligibility and timing through the responsible clinician.

## Viva Questions and Answers

### Why discuss alternatives before sterilisation?

Understanding temporary and permanent options supports informed consent.

### What determines eligibility after delivery?

Timing, breastfeeding, complications and other medical factors affect method choice.

# Cervical Screening and Pap Smear Model

Practical 06 / Skills laboratory simulation

## Aim

Explain cervical cancer prevention and demonstrate a Pap smear workflow on a pelvic model.

## Principle

HPV vaccination and appropriate screening reduce cervical cancer burden. HPV testing, cytology and visual methods have different roles in screening and triage pathways.

## Materials and Requirements

- Pelvic model, speculum and approved collection device with mock specimen container
- Fictional HPV, cytology, VIA and VILI results

## Procedure

1. Explain the purpose, procedure, alternatives, privacy and follow-up. Obtain simulated consent and offer a chaperone.
2. Establish whether the case is routine screening or symptom assessment, review test purpose and consent and identify privacy, chaperone and result communication arrangements.
3. Verify identity, specimen type and test request. Set up the model and simulate visualising the cervix with the speculum.
4. Check mock identifiers, sample medium, expiry and request. With adequate lighting prepare the pelvic model and demonstrate speculum approach and cervix visualisation under the instructor’s direction.
5. Use the kit’s approved collection method on the model. Transfer the specimen to the medium or slide as directed and label it with identifiers and site.

Continue with step 6 on the next page.

# Procedure Continued

Cervical Screening and Pap Smear Model

6. Identify the target area on the model and use the kit's approved collection and transfer method. Complete the mock label, indicating date, test, site and collection limitation where relevant.
7. Compare HPV testing, Pap cytology, visual inspection with acetic acid or Lugol iodine and the role of colposcopy for appropriate referrals.
8. Compare cytology, HPV tests and visual methods using the case pathway and describe the result that requires referral or colposcopy. Distinguish triage and clinical evaluation needs.
9. Document any collection limitation, result route and follow-up responsibility.
10. Link the lab form and model specimen, document adequacy concerns and confirm who reviews the result. Tell the actor when and how they would receive it.

## Precautions

- Use a pelvic model for technique practice.
- A patient with concerning symptoms needs clinical evaluation even if previous screening was reassuring.

# Observations and Interpretation

Cervical Screening and Pap Smear Model

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Prevention | Vaccine status and screening indication | Supports a tailored discussion |
| Specimen | Technique, site, medium and label | Determines result quality and traceability |
| Result plan | Test type, follow-up and clinician responsible | Reduces missed follow-up |

### Worked Example

A model case has a positive high-risk HPV screen and no symptoms. The student uses the current screening pathway to identify the required triage and explains when results will be discussed.

## Result and Interpretation

A positive screening result requires appropriate follow-up. Explain the test meaning and the next step without treating a screening result as a cancer diagnosis.

## Viva Questions and Answers

### Why label the specimen at collection?

It links the correct patient and site to the test.

### What is colposcopy used for?

Magnified assessment of the cervix with targeted evaluation, including biopsy when indicated.

# Obstetric Case Record Referral and Discharge

Practical 07 / Clinical or documentation case

## Aim

Prepare a complete case record, a focused referral and a patient-friendly discharge summary.

## Principle

A clear record links findings to decisions and identifies responsibility. Referrals transmit the current problem and urgency. Discharge notes support follow-up and safety.

## Materials and Requirements

- Fictional obstetric chart, referral and discharge forms
- Local communication and handover checklist

## Procedure

1. Establish symptoms, gestation or postpartum timing, previous history, examination and observations. Enter dates and times for material events.
2. Construct a dated time line with gestation or postpartum day, symptoms, pertinent past events and changes in maternal and fetal findings. Verify entries against the case record.
3. Write a provisional impression and differential. List key investigations, treatment and response. Quote the relevant positive and negative findings.
4. Summarise the relevant findings and working assessment, including intervention, response and unresolved questions. Make clear which observations were reported and which are documented.

Continue with step 5 on the next page.

# Procedure Continued

Obstetric Case Record Referral and Discharge

5. Draft the referral stating reason, acuity, essential maternal and fetal facts, actions and contact details. Confirm handover receipt in the scenario.
6. Prepare a referral with time, receiving team, reason and acuity, current status, treatments, pending results and requested action. Ask the receiver to confirm the handover.
7. Draft the discharge summary with diagnosis, procedures, medicines as verified, pending results, return precautions and follow-up dates.
8. Write the discharge summary with verified medicines, planned follow-up and specific return precautions. Allocate responsibility to review pending tests and clarify how the person will be contacted.
9. Explain the plan, invite questions and ask the patient to repeat the most important next steps.
10. Check teach-back in plain language and record next appointment, transport or access needs and contact route. Update the note when the case changes.

## Precautions

- Use simulated identifiers in student records.
- Verify the final note and medication list with the supervising team.

# Observations and Interpretation

Obstetric Case Record Referral and Discharge

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Case timeline | Presentation, examination and intervention times | Connects findings to decisions |
| Referral | Acuity, current status and request | Clarifies the receiving team's role |
| Discharge | Plan, warnings, pending results and named follow-up | Supports continuity |

### Worked Example

A postpartum patient is clinically stable in the discharge case. One result remains pending. The note identifies which team will review it and how the patient will be contacted.

## Result and Interpretation

A complete discharge includes both follow-up timing and ownership of unresolved results. Document that the patient understood when to return.

## Viva Questions and Answers

### What makes a referral specific?

It states why review is needed, how urgently and which current findings or actions affect care.

### Why put pending results in the summary?

It gives the patient and teams a clear route for follow-up.

# Universal Precautions and Urinary Catheter Model

Practical 08 / Skills laboratory simulation

## Aim

Use standard precautions and demonstrate sterile urinary catheter setup and follow-up on a task trainer.

## Principle

A documented indication, aseptic insertion and a closed drainage system limit avoidable harm. Standard precautions apply to all patients.

## Materials and Requirements

- Urinary catheter trainer, training catheter, approved kit and closed drainage bag
- Personal protective equipment and catheter record

## Procedure

1. Verify indication, identity, consent, allergies and the role of a chaperone. Review facility exposure and infection prevention processes.
2. Verify documented need, model identifier, consent, allergies and appropriate catheter choice with the instructor. Prepare a private station, correct safety supplies and an approved disposal route.
3. Perform hand hygiene, select protective equipment for the task and establish an aseptic field. Check the packaging and catheter details.
4. Establish an aseptic field and separate clean and used items. Inspect catheter, connections and collection system, and verify kit instructions before the demonstration.

Continue with step 5 on the next page.

# Procedure Continued

Universal Precautions and Urinary Catheter Model

5. On the model, demonstrate the approved placement checklist. Confirm the simulated signs of placement before the balloon step as directed by the faculty.
6. On the trainer position and prepare the model as instructed. Protect key parts, demonstrate placement checks and pause for faculty review if expected model drainage or feedback is absent.
7. Secure the device, maintain a closed system and place the drainage bag below bladder level. Record urine output and catheter information.
8. Keep tubing free of kinks and preserve the closed drainage system. Secure it without tension, keep the bag appropriately below the bladder and document fluid measurements and checks.
9. Set a review or removal plan. Explain the immediate actions and reporting pathway after a simulated blood or body-fluid exposure.
10. Record insertion date, time and indication, including who will reassess. Rehearse procedure for contamination or exposure and identify how to communicate any problem.

## Precautions

- Use a trainer and avoid forcing insertion.
- Report aseptic breaks and exposure incidents immediately.

# Observations and Interpretation

Universal Precautions and Urinary Catheter Model

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Preparation | Indication, identity, protection and equipment | Verifies safe procedure setup |
| Model check | Placement confirmation, drainage and securement | Supports safe ongoing care |
| Review | Time, output and indication reassessment | Limits unnecessary catheter days |

### Worked Example

The model catheter drains no simulated urine and resistance is reported. The student stops and asks the instructor to check position before proceeding.

## Result and Interpretation

Confirm correct position and review the reason for failed drainage. Continue only with the trainer checklist and instructor guidance.

## Viva Questions and Answers

### What helps prevent retrograde flow?

An unobstructed closed system with the collection bag below bladder level.

### Why record the indication?

It allows the team to reassess necessity and remove the catheter promptly when appropriate.

# Amniotomy and Episiotomy Skills Models

Practical 09 / Skills laboratory simulation

## Aim

Prepare and demonstrate assigned amniotomy and episiotomy repair skills on approved trainers.

## Principle

Each procedure needs its own indication, consent and safety checks. Monitoring and clear documentation support recognition of complications.

## Materials and Requirements

- Labour and perineal repair trainers, dummy instruments and practice sutures
- Fetal heart card, sterile practice pack and procedure checklists

## Procedure

1. Explain the indication, benefits, material risks and alternatives in each fictional case. Check approval, consent, patient information and aseptic setup.
2. Review the individual indications and verify simulated permission, medication or analgesia needs, aseptic setup and team readiness before the separate model skills.
3. For amniotomy, confirm the supervisor's assessment of presentation, engagement and contraindications. Record the fetal heart assessment before the model demonstration.
4. Confirm the provided presentation, engagement and contraindication assessment. Enter the fetal heart finding and request senior confirmation when the supplied findings make proceeding unsafe.
5. Demonstrate the amniotomy sequence on the trainer. Record the simulated time and fluid characteristics and reassess the supplied fetal heart trace.

Continue with step 6 on the next page.

# Procedure Continued

Amniotomy and Episiotomy Skills Models

6. On the trainer demonstrate the faculty-approved sequence, then describe fluid colour or other observations and compare fetal heart data before and after. Escalate a simulated sudden change.
7. For the perineal model identify tissue layers, check the analgesia plan and demonstrate faculty-approved repair and sharps handling.
8. On the repair pad identify layers and landmarks and verify anaesthesia readiness and instrument count. Demonstrate the approved repair and point to expected approximation and haemostasis checks.
9. Document method, findings, counts, reassessment and any complications requiring the team.
10. Complete separate records for the two exercises with timing, reason, findings, team action and reassessment. Record counts, disposal and any deferred step or escalation.

## Precautions

- Perform the invasive training steps on approved models.
- Escalate new fetal heart changes or persistent bleeding promptly.

# Observations and Interpretation

Amniotomy and Episiotomy Skills Models

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Readiness | Indication, consent, examination and prepared setup | Determines whether to proceed |
| Amniotomy record | Time, fluid and fetal heart before and after | Detects change needing review |
| Repair record | Layers, haemostasis checks and counts | Documents completion and follow-up |

### Worked Example

In the amniotomy model case the presenting part is high and not well applied. The student identifies the concern and stops to request senior assessment.

## Result and Interpretation

Defer the simulated step until risk is reviewed. Artificial rupture and episiotomy require individual indications and clinician supervision.

## Viva Questions and Answers

### Why check the relation of the presenting part before amniotomy?

A high or poorly applied part can increase the risk of cord prolapse.

### What care information belongs in a repair note?

The injury extent, repair, analgesia, counts, checks and follow-up.

# Gynaecology History Bleeding and Pelvic Mass

Practical 10 / Clinical or documentation case

## Aim

Record a focused gynaecological history and interpret initial investigations for bleeding or a pelvic mass.

## Principle

Age, pregnancy possibility, bleeding pattern, pain and imaging guide the differential and urgency. Examination and tests should match the clinical question.

## Materials and Requirements

- Fictional case cards, pelvic model and investigation reports
- Case record and patient counselling checklist

## Procedure

1. Ask about cycle timing, bleeding volume and pattern, pain, contraception, pregnancy possibility and relevant medicine or cancer history.
2. Take a time line of menstrual pattern and unexpected bleeding, pain, possible pregnancy and risk factors. Record effect on function and whether urgent symptoms are present.
3. Check vital signs and symptoms of anaemia or shock. Explain the external general and abdominal examination. Use a model for intimate examination teaching.
4. Check circulation, pulse, blood pressure and signs of anaemia. Obtain consent for external or simulated examination and describe area, mass or tenderness in a consistent anatomical sequence.

Continue with step 5 on the next page.

# Procedure Continued

Gynaecology History Bleeding and Pelvic Mass

5. Review a pregnancy test when indicated, full blood count and the ultrasound report. Describe the mass by site, size and reported features.
6. Align pregnancy test, full blood count and ultrasound with the visit date. Document mass site and measurements, associated findings and limits of the image before suggesting likely causes.
7. Identify urgent or specialist referral indications, including haemodynamic compromise, severe pain or postmenopausal bleeding.
8. Check for severe bleeding, acute pain, instability or new postmenopausal bleeding. State the appropriate level of referral along with the clinical finding that determines urgency.
9. Summarise the working differential and explain the next evaluation and return precautions.
10. Present a concise assessment and explain the next test or review with clear timing. Document the responsible team, return indications and any result still pending.

## Precautions

- Obtain explicit consent before any examination and follow chaperone policy.
- Escalate suspected haemorrhage, acute pelvic emergencies or pregnancy-related instability promptly.

# Observations and Interpretation

Gynaecology History Bleeding and Pelvic Mass

## Observations and Record

| Item | What to record | What it tells you |
|---|---|---|
| Bleeding and pain | Onset, timing, amount and pregnancy possibility | Defines initial differential |
| Examination | Stability, pallor and abdominal findings | Establishes urgency |
| Tests | Pregnancy result, haemoglobin and imaging descriptors | Supports targeted evaluation |

### Worked Example

A fictional patient reports new bleeding after 18 months without menstruation. The vital signs are stable and the student documents the symptom and timing.

## Result and Interpretation

Postmenopausal bleeding needs timely specialist evaluation. Explain that multiple causes are possible and arrange follow-up through the local pathway.

## Viva Questions and Answers

### Why check pregnancy possibility in reproductive-age bleeding?

It changes the differential, urgency and choice of tests.

### Why document the bleeding pattern carefully?

Timing and duration guide choice and urgency of assessment.

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