Candidate's name:	
Country of origin:	Philippines
Email address:	

NEU Professionals
INTERNATIONAL HEALTHCARE RECRUITMENT

Midwifery skills and experience – CV addition

Indicate in relevant box your level of experience:

1	Competent	2	Limited Experience	3	No experience

Procedures	1	2	3	How many?	Comments	
Please indicate your level of competency and provide the number of women in labour you have cared for in the last 12 months	1			300	Labour & Delivery unit (current hospital) has 4 beds for early labour clients with h/o PROM/PPROM and for those high risk cases in latent phase of labour who needs close fetomaternal monitoring. Also, there are 2 beds for Induction of Labour and 10 beds for clients in active stage of labour/ ARM + oxytocin augmentation cases.	
Please indicate your level of competency and provide the number of babies delivered in the last 12 months	1			230	Assuming that I have conducted 1 delivery per shift in 12 months but in most cases, it is 2 deliveries per staff per shift depending on the staffing and the rate of admission and number of deliveries per shift. There are also times that clients do not deliver in our shift and there are times I have conducted 3 deliveries in 1 shift.	
Please indicate your level of competency Post-Partum Care - mother	1			230	Assuming that I have conducted 230 deliveries in 12 months. Per the hospital's protocol, we monitor postpartum clients up to 2 hours before shifting and endorsing care to postnatal ward if client is stable. If there were obstetric emergencies involved, we monitor client in Labour ward up to 4 hours postpartum.	
Please indicate your level of competency Post-Partum Care - new born	1			230	Assuming that I have conducted and delivered 230 babies in 12 months. Healthy babies are kept for rooming-in with their mothers while sick babies are being shifted to NICU.	
Please indicate your level of competency Infant Feeding Support- no of women	1			230	Assuming that I have handled 230 deliveries in 12 months. We encourage early and exclusive breastfeeding for at least 6 months up to 2 years and mothers are taught of breastfeeding cues, latching, positions, and benefits of breastmilk.	
Please indicate your level of competency Antenatal care- number of women provided an ante natal check	1			300	Early labour clients with high risk factors and threatened preterm labours are being admitted to Labour Ward for monitoring.	
Experience in Obstetric Emergencies in the last 12 months– please provide details of	1				Had experience handling obstetric emergencies like shoulder dystocia, cord presentation and cord prolapse, assisted breech delivery, preeclampsia, antepartum hemorrhage, postpartum	

first-hand experience and when you assisted as part of team.in the comments section					hemorrhage, maternal and neonatal resuscitation, and fetal distress/ non reassuring CTG.	
Experience in Shoulder Dystocia– please provide details of first-hand experience and when you assisted as part of team.in the comments section	1				(Recent case) I had 1 client (multigravida, term, morbidly obese, no other risk factor) who came in second stage of labour. Client came bearing down, perineum was bulging and fetal head visible. CTG was attached and client was prepared for delivery. There was difficulty delivering the anterior shoulder after baby's head was out so emergency bell was pressed, situation was explained to the mother, bed was broken and placed client in McRobert's position; still unable to deliver the anterior shoulder so suprapubic pressure was applied and baby was delivered successfully with mild shoulder dystocia at the same time obstetricians came to assess the situation; baby was born with vigorous cry and good Apgar score so skin to skin contact was initiated with the mother and delayed cord clamping done for 1 minute before handing over the baby to pediatrician; active management of third stage was done; mother was reassured and complete documentation was done.	
Experience in Post-Partum Haemorrhage– please provide details of first-hand experience and when you assisted as part of team.in the comments section	1				09/2021- I conducted 1 primigravida 39 weeks who experienced prolonged second stage of labour (2 hours and 30 minutes). She had mild PPH; oxytocin infusion was already ongoing, syntometrine 10 units was also given IM after placental delivery, and urinary bladder was emptied prior to delivery via urinary catheter, uterus was relax, so emergency bell was pressed; situation was explained to the mother, fundal massage was done and blood clots was expelled; 2nd dose Inj. Syntometrine 10 units given IM; maternal vital signs checked; Misoprostol 1000 mcg was given PR by doctor; uterus became contracted and blood loss became minimal, placenta and membranes was complete, episiotomy was sutured in layers, client reassured, vital signs was closely monitored for the first 2 hours postpartum and complete documentation was done. (Estimated blood loss- 800 mL).	
Experience in Neonatal Resuscitation– please provide details of first-hand experience and when you assisted as part of team.in the comments section	1				09/2021 – I assisted 1 vacuum delivery for fetal distress. Baby was born flat. Initial steps of resuscitation was taken (dried, provided warmth, oral and nasal suctioning done, stimulation done) baby was still unresponsive, DCC lasted only for 30 seconds and baby was	

					taken for neonatal resuscitation; pediatrician came over, SPO2 monitor attached, Heart rate was below 100 bpm so ppv was given for 30 seconds, afterwards heart rate rose to 120 bpm, SPO2 95 %, baby also started to cry and colour was improved. Baby was shifted to NICU for post resuscitation care.	
Experience in Maternal Resuscitation – please provide details of first-hand experience and when you assisted as part of team.in the comments section	1				(Pre-covid case) Emergency bell was pressed and I attended the call. 1 client in early labour had cardiac arrest and the 1st responder was already initiating CPR. I came as a 2nd responder and I activated the Cardiac Arrest Team (consists of anesthetist, physician, ICU staff, nursing supervisor, Biomedical support staff). Then I brought the crash cart in the room and put on the timer. I took out the chest board from the crash cart and placed it under the client's back, repositioned the bed and headboard was removed. After I opened the airway by head tilt- chin lift and gave rescue breaths using bag mask ventilation (CPR 30:2). 3rd rescuer came and oxygen was connected to the ambubag, cardiac monitor was attached, ECG rhythm showed asystole (non shockable), CPR was resumed and IV line was running in bolus and emergency drugs were administered, client was intubated by the anesthetist, FHR was bradycardia and client still has no signs of life so perimortem LSCS was done, baby was handed over to pediatric team for resuscitation and mother was revived after. Continous hemodynamic monitoring was done and IV fluids maintained. Client was soon shifted to ICU; husband and relatives were informed by the doctors of the situation. Incident report was written and complete documentation was done.	
Experience in unexpected breech birth please provide details of first-hand experience and when you assisted as part of team.in the comments section		2			04/2021- I received 1 multigravida, term pregnancy who was initially posted for LSCS for breech presentation after unsuccessful ECV but client refused and was keen on spontaneous delivery. All risks was explained to her and she was induced with prostaglandin gel. Continous CTG monitoring was done when she started getting adequate uterine contractions. When she reached second stage of labour, I called for help (midwives, obstetricians, and pediatrician came). Situation was again explained to the mother. IV hydration was infusing. Client was placed in lithotomy position, continous	

					fetomaternal monitoring done, bladder was emptied via urinary catheter, perineum was lax so episiotomy not given, obstetrician took over the delivery, pinard's maneuver was done and mother was encouraged to bear down until the scapula was visible, loop of cord was pulled down to prevent cord compression and cord pulsation was checked, lovset maneuver was done and baby's head was delivered by jaw flexion and shoulder traction. After delivery, baby was shown to mother and handed over to pediatrician. I took over placental delivery and active management of third stage of labour was done, mother was reassured, vital signs checked and complete documentation was done.	
Experience in caring for deteriorating patients – please provide details of first-hand experience and when you assisted as part of team.in the comments section	1				(Covid case) 1 client in early pregnancy was admitted for shortness of breath. Vital signs was monitored and SPO2 was 90% at room air. Oxygen by mask given at 8 lpm and SPO2 improved to 94-95 %. She has no comorbidities. Covid test was taken and result was positive. Client was taken to isolation room and kept comfortable on bed on high – fowler's position. Client and relatives were informed about client's case. Blood investigation results were deranged. Continous maternal monitoring was done and medications were started. Cardiac monitor was attached. Client was kept hydrated. After 2 hours, client experienced further desaturation SPO2 88% despite high oxygen flow and had complaints of difficulty of breathing. Respiratory therapist and physician were informed and client was connected to CPAP. Client was soon shifted to ICU Covid ward for close monitoring. The situation was explained to client and her relatives. Complete documentation done.	
Pre-Eclampsia – please provide details of first-hand experience and when you assisted as part of team.in the comments section	1				10/2021- 1 G7P4M2 38 + weeks gestation admitted for BP 190/110 mmHg and complaints of headache (initial diagnosis: Chronic Hypertension with superimposed PIH); called for help; explained situation to the client; doctors were informed; kept client on lateral side and observed for signs of impending eclampsia; vital signs and FHR checked; 2 G 18 cannula inserted and PIH blood investigations taken; trandate infusion started and titrated every 30 minutes depending on	

					BP reading; Magnesium sulphate bolus given slow IV push followed by MgSO4 infusion; foley's catheter was inserted and urine output was measured hourly; urine analysis was done; client was kept on NPO; CTG was reactive and when vital signs became stable, client was induced with 1 mg prostaglandin gel. Client was closely monitored for signs of MgSO4 toxicity like respiratory depression, inadequate urine output. She did not deliver in my shift but she had uneventful spontaneous vaginal delivery with active management of third stage of labour and MgSO4 maintenance was infused for 24 hours post delivery.	
Experience in Perineal Suturing– please provide details of first-hand experience and when you assisted as part of team.in the comments section	1			230	In Oman, midwives are authorised and trained to repair episiotomy, 2nd degree tear, 1st degree tear, paraurethral and labial tears and skin lacerations. Doctors suture 3rd degree, 4th degree and multiple lacerations.	
Venepuncture	1			300	Upon client's admission, we collect blood for laboratory investigations.	
Cannulation	1			300	We do cannulation to all admitted clients and collect blood at the same time for laboratory investigations.	
Management of Epidural Anaesthesia – please provide details of first-hand experience and when you assisted as part of team.in the comments section		2		10	We provide epidural anesthesia only upon client request. Vital signs should be stable, FHR normal, blood investigation result especially coagulation profile should be normal before notifying the anesthetist. Then client is counselled with benefits and possible risks, consent for the procedure taken and after procedure, the client is closely monitored for hypotension and other potential side effects.	
Water Birth			3			
Home Birth			3			

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