OBSTETRIC NURSING.

— By Obstetrica, M.B.N.A. —

PART I.—MATERNAL.

Chapter III.—Duties Immediately After Delivery.

THE first Nursing duty when your patient is put straight after her delivery is to bind her. I shall do my best to describe how to do this properly and well; but I regret to say that, as far as my experience as a teacher goes, we have more "friction" during training days and more "backsliding" afterwards in the matter of obstetric binding than anything else. The evil arises from *want of attention to instructions*. By way of illustration we will give our younger readers a pen and ink sketch of a lesson in binding to a Nurse "who does *not see* that there is much to learn in it," for there is wisdom to be learned from the negative side of things, if we only try to do so. The pupil stands at my right hand—about half-way up the bed—and on the right side (I am towards the head of the bed). The first point we observe is that the glances of our pupil are directed upwards towards the ceiling (whether seeking inspiration or counting flies we cannot understand). Judging from results, I think my readers will agree with me that the latter hypothesis is by far the more tenable. Mildly suggesting that a glance should be bestowed upon the mundane work before us, our pupil makes a beginning—wrong, of course. The binder has been placed for her, as it is only a readjustment case, for my Nursing readers may be sure that under no other conditions would the eccentricities I am about to describe be permitted. The left side of the binder is rolled up for her, and put in her right hand, and she is shown how to place the two sides together at the bottom fairly level. Instructions as to the proper placing and spacing of the pins might almost as well be delivered in Sanskrit, so little are they heeded. I described to you in a former paper the sort of pins I prefer for obstetric binding. With much misdirected energy our friend rams down the "heads"; as for the "points," they do what they like, and they generally like to bury themselves *in* the folds of the binder, to the much comfort of the bindee. Some of the pins are put in in an *oblique* direction, and get bent and spoiled, however good they may be, and their honourable career as pins is brought to an untimely end. It is also the opinion of our friend that when the sides of the binder are drawn together before pinning, it must be done with short, sharp "jerks," that shake the bed; and when we consider that these remarkable upheavals take place six or seven times in succession, their soothing influence upon the patient can be fully appreciated. Moreover, in pinning our friend pursues a sort of *spiral* ascending course, and the higher she gets up, the more hoplessly is the binder twisted in itself. When the pins are all placed (?), this is the sort of thing that meets our gaze. The outer or left side of the binder is *at least* six inches higher than the inner or right side, which presents a beautifully corrugated appearance, commonly called "rucks"; as for any attempt to place the top sides of the binder level with each other it is perfectly impossible, for they have long since ceased to be "on equal terms."

Our little comedy is drawing to its close, but as far as the chief personage in it is concerned, a silent and relentless Nemesis is awaiting her, as it does all wrong-doing whatever. All those pins put in with such disregard to instructions have to be taken out again with her own hands. And a right penal task it is! The pins have taken such a violent fancy to the binder, that it is the hardest matter in the world to separate them; and broken thumb nails and sore finger ends sadly bring home to the pupil the fact that if she began her lesson under the idea that there was not much *to learn*, there was distinctly something to *unlearn;* so for the present we will leave her a sadder if not a wiser woman than when she began her lesson.

Let us return to our patient. You have the binder smoothly rolled to about a third of its length; as I told you before, the open side is to be placed upwards and the smooth side downwards when it is applied. It is to be placed next the skin, and put on in the recumbent position. Turn the bed-clothes back as far as necessary from *right* to *left* sidewise, *never* from top to bottom. Observe this plan as an *undeviating* rule, whatever may be the bed-side duty you may have to perform for your patient, as by this plan you prevent unnecessary exposure and chilling. Requesting your patient to draw up her knees, and keeping her shoulders flat on the bed, to raise herself up on her heels, you quickly with your left hand pass the binder under her, the rolled end downwards towards the bed, and leaving it there, with both your hands adjust the loose end of the binder into position. It should more than half cover the abdomen, and be carried three or four inches beyond the median line. With respect to the pelvic position of the binder, it should be placed about an inch below the trochanter, which as you know projects slightly from the top of the femur; it is a sure landmark for us—and useful on that account—and pulling the binder thus far down, it embraces the whole of the pelvis, which is an

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