STANDARD OPERATING PROCEDURES (SOPs)

FOR
OBSTETRICS & GYNAECOLOGY(02)

Book 1

Department of Health & Family Welfare, GNCTD

SOP for Obstetrics & Gynaecology,
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Quality Assurance Cell
Delhi State Health Mission
Department of Health and Family Welfare
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Compilation facilitated by : State QA Cell (Nodal Officer: Dr. Monika Rana , Consultant : Ramesh Pandey , Communitization Officer : Arvind Mishra , Statistical Officer : Shahadat Hussain), ARC (Maneesh and Md. Irshad Ansari).
Designed and Formatted by: Graphic Designer : Mansi Rana

DETAILS OF THE DOCUMENT

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This Document is prepared by the expert committee comprising of:

Sl. No.	Member	Designation	
1.	Dr. Anjali Tempe	Director Professor & M.S. (MCH), MAMC & Lok Nayak Hospital	Chairperson
2.	Dr. Amita Suneja	Director Professor & HOD ,UCMS and Guru Teg Bahadur Hospital	Member
3.	Dr. Mirnalini Mani	Specialist & HOD ,Guru Gobind Singh Govt. Hospital	Member
4.	Dr. Anshuman Kumar	M.S. (MCH),Jag Pravesh Chandra Hospital	Member
5.	Dr. Poonam Joon	Specialist, Sanjay Gandhi Memorial Hospital	Member
6.	Dr. Chetna Arvind Sethi	Specialist ,Lok Nayak Hospital	Member
7.	Ms. Laxmi Narang	Nursing Sister, Deen Dayal Upadhayay Hospital	Member

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AMENDMENT SHEET

S.No.	Page No.	Details of the amendment	Reasons	Signature of the preparatory authority	Signature of the approval authority

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OBSTETRICS & GYNAECOLOGY-OUTPATIENT DEPARTMENT

1.1 Purpose:

Purpose of this SOP is to ensure that all patients Attending OPD are attended and provided with quality care in an environment of minimal risk, covering every aspect of patient care from the time patient walks in the registration counter, to consultation and examination room, through diagnosis, treatment and follow-up of the patient in the Hospital.

1.2 Scope:

This SOP covers all the processes and guidelines to be followed by all doctors, nurses, paramedical and other support staff involved in the management of the patient in the OPD. It includes provision of preventive, diagnostic, curative and rehabilitative services to the patient attending OPD. This also entails management of inventories, cleanliness, security, record keeping and repair and maintenance of equipment.

1.3 Responsibility:

HOD, specialists, medical officers, senior residents, nursing sister OPD and respective security and sanitation staff..

1.4 Procedure:

A. Assess, Assessment and continuity of care:

S.No.	ACTIVITY	RESPONSIBILITY	REFERENCE
1.4.1 Registration of patient			
A.	• Signage for OPD clinic and their timings should be displayed prominently. • Timings and days for special clinics to be displayed in OPD. • Timings for registration should also be displayed prominently. • Rules, regulations, patients rights, responsibilities also be displayed prominently. • NO smoking, signage in OPD should be displayed prominently. • There should be a help counter near the entrance to guide and help needy patients. Trolleys and wheel chairs for patients should be available in adequate numbers at help counter. **Registration of the patient**: Any patient requiring OPD services can get registered by one of the 2 methods. a) By visiting the hospital and get registration done in any OPD registration counter. An OPD card is issued to her with assigned OPD room No. b) Recently Delhi Government has launched an on-line OPD registration application, patient can generate an online OPD card.	MS / DMS Social workers Registration counter Clerk/ Patient herself	

1.4.2 Patient calling system in OPD			
	Patient Calling System And queue Management: a) Patients should be provided with a token preferably from the registration counter or it can also be provided by the Guard/ N.O outside the consultation room. **<u>All the number may be put directly on the OPD slip by the registration counter.</u>** b) Patients are called one by one to the consultation room. c) There should be preferably an electronic display board for display of token number at every OPD.	Security Personnel, Nursing Orderly OR Social Worker	IPD
1.4.3 Receiving of patient in OPD			
A.	• Patients are called by calling patient's name/token number. • Patient is asked to sit comfortably & communicate with doctor.	Attendant N Nursing Orderly	

1.4.4 OPD Consultation			
B.	• A detail history and complete physical assessment of the patient to be done in a designated examination room / area in complete privacy taking appropriate precautions and hygiene. **(respect the women's dignity and right to privacy)** • The details of history and clinical examination, allergies etc. shall be appropriately recorded in the OPD slip. • After history and evaluation try to make a diagnosis /provisional diagnosis wherever feasible and Plan treatment accordingly. • Record the diagnosis and ICD-10 code on the counter foil of OPD and keep the counterfoil for records. • Discuss the possible treatment options with the patient and prescribe treatment accordingly. • Prescribe and also communicate the patient clearly about precautions, investigations and follow-up visits wherever applicable. • Referral: Patient seen in one OPD and referred to other OPD should be seen **preferably** on priority basis, and should be entertained on same OPD card. However patient is instructed to make a fresh card for the referred OPD on her next visit. • If a patient visits OPD on a wrong day she should not be returned but seen and treated and also instructed to follow on her designed OPD days. • Patients should be prescribed medicines as per the essential drug list. Requisite SDF, investigation slips to be issued by the doctor. • Sick /patient requiring expert advise should be referred to consultant **/ Senior Doctor whenever required.** • Referral of patient to other department must be done in consultation of the specialist **/ SR depending on the case.** • When no definite diagnosis can be made patients should not be shuttled from one OPD to other OPD unnecessarily. **Depending upon the condition of the patient** such patients should be admitted **if sick** and proper references to be obtained by the different departments **(after admission). Referral may be done by telephonic consultation at OPD level also.**	Doctor on Duty	
D.	**Referral :** • All patient requiring advice of different specialty should be appropriately referred. • Sick Patients requiring emergency/ labor room should be referred and shifted immediately from OPD, with staff and written advice.	Doctor on Duty	

1.4.5 Investigations:			
E.	• Investigation/ Imaging should be prescribed to the patient as per the requirement, and referred to the OPD Lab. • Appropriate investigation slips to be provided to the patient duly filled and signed by the prescribing doctor. • Any precaution/ preparation required for the investigation must be explained and recorded in the OPD/ investigation slip. • Patient should be clearly guided for day and date for collection of reports.	Doctor on Duty, Staff Nurse, & NO	**Annexure**:2, FORM –F
1.4.6 Prescription and drug dispensing			
A.	**The prescription :** • The prescription should always contain the presenting complaint, brief history, family history, physical examination, vitals recorded during examination, a provisional diagnosis, investigation and imaging prescribed, drug along with dose and duration,. • Medication orders should be clear, legible, with date, sign and stamp. • Appropriate doses and duration shall be clearly mentioned in the prescription. • Patient should be informed of possible serious side effects and should be advised what needs to be done if such situation arises. • Possible drug/ food interactions should be assessed while prescribing and advised / prescribed appropriately. Consult senior doctor **/ SR** in OPD while prescribing a high risk medication to the patient. **The list of these drugs should be available in the OPD.**	Doctor on Duty	

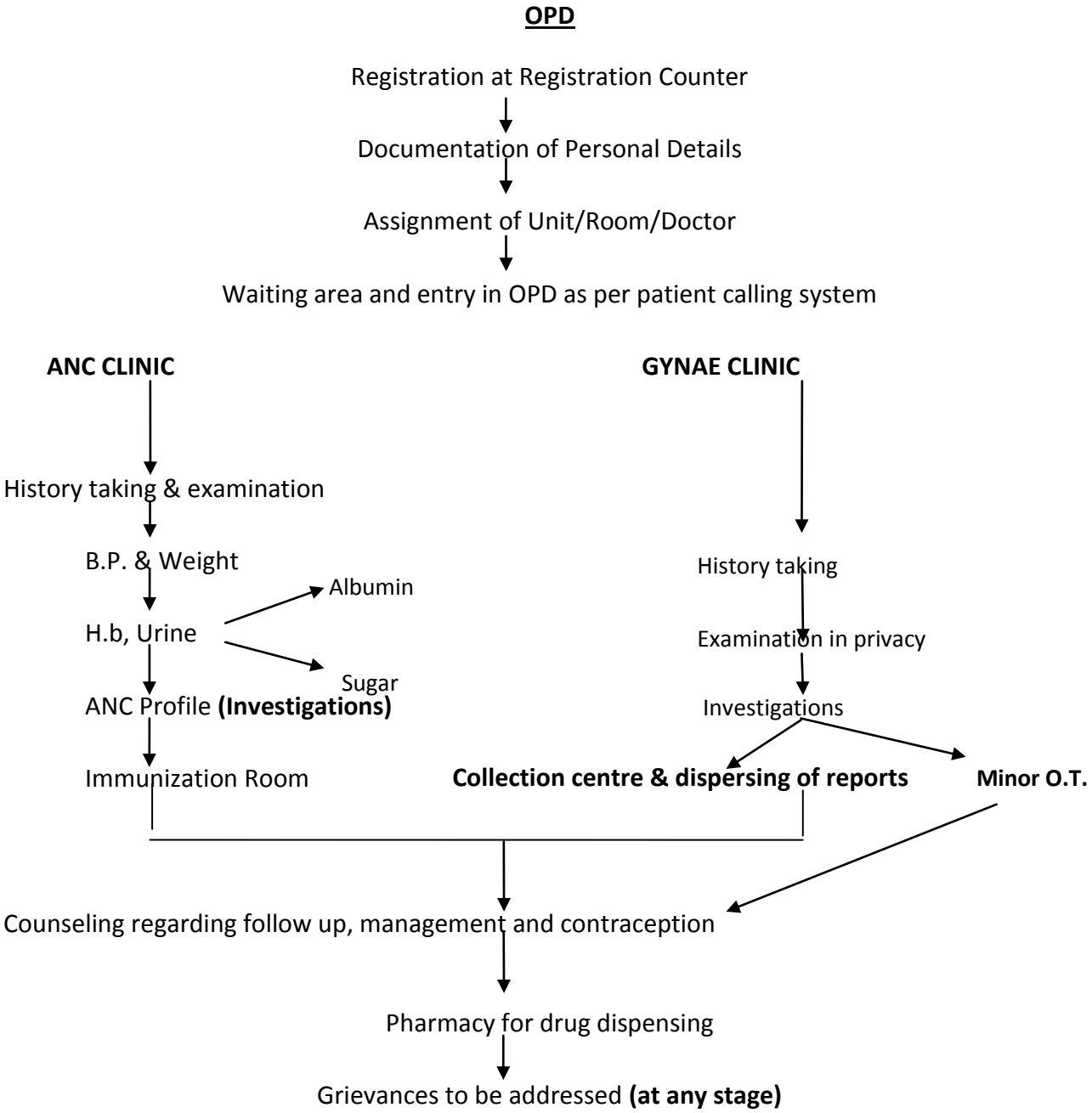
B	**Drug dispensing** • Pharmacy counters should be located in OPD. • Opening, closing and lunch timing should be prominently displayed in pharmacy. • There should be a proper queue management system for every pharmacy counter. • There should be a sitting arrangement for patients in the pharmacy along with an electronic display system. • Doctors prescription should be honored, and drug dispensed as per the dose and duration prescribed. • If there is any discrepancy or ambiguity in the prescription pharmacist must consult the doctor on phone to clarify and patients should not be shuttled . • Patient should be instructed about the doses and precautions as per the prescription. • Pharmacy counters should not be closed before finishing the queue toward the end of the day. • Pharmacy in-charge must ensure that no patient prescribed should be returned from the counter. • There should be a complaint readdressal system for pharmacy.	Pharmacist	
1.4.7 Nursing processes in OPD			
	• Maintenance of Cleanliness and sanitation in OPD area . • Record keeping. • Assistance to doctors. • Maintenance of instrument and equipments. • Counseling and addressing issues pertaining to patient. • Provision of healthy and conducive environment in OPD. • Management of injection room and minor OT. • Bio-medical waste management. • Ensuring adequate supplies of consumables. • To supervise the quality of patient care and assist in patient satisfaction survey.	I/C Nursing OPD.	
1.4.8 Patient privacy and confidentiality.			
	• Confidentiality and privacy is one of the fundamentals rights of the patient. It should not be violated by any member of the OPD patient care team. • Care should be taken while examining a female patient in OPD by a male doctor. It should preferably be done in presence of staff nurse. • No detail of medical condition of any patient (written or verbal) should be divulged to any one. • Medical record of patient to be handed over to the patients only and in case of minor/ mentally challenged patients records to be handed over to the authorized attendant only.	OPD team (All staff members)	

1.4.9 Conducting and analyzing patient satisfaction survey		
• PSS conducted at periodic intervals • PSS shall be taken up every month and data collected shall be analyzed. • **Sample Size:** As per the Patient load. Statistically correct sample can be referred from the Annexure of General Admin SOP. • There shall be one person designated to co-ordinate satisfaction survey. • Results of Patient satisfaction survey are recorded and disseminated to concerned staff • Patient feedback form are available in Hindi/English language • Department prepares the action plans for the areas of low satisfaction	DMS Administration	**Annexure 3** : OPD Patient Satisfaction survey Form Detailed information about PSS methodology is present in General Administration.
1.4.10 Equipment management and maintenance in OPD		
• Nursing staff (OPD) should maintain a log register of all the major equipment installed in OPD and an inventory of all instrument in OPD. • Status of all equipment should be checked by staff nurse. • There should be a schedule for cleaning and preventive maintenance of all equipments. • All vital and life saving equipment should be covered under AMC/CAMC. • There should be an arrangement for backup of all vital equipments. • Vendor/ Supplier/ R&M branch should be informed immediately for any fault/ requisite repair. • All unused/surplus/ irreparable/ damaged/ equipment and instruments furniture and linen items to be condemned and replaced.	I/C Nursing R&M Office of Hospital	SOP for Repair & maintenance of Medical equipment

1.4.11 Administrative and Nonclinical work at OPD			
	• Maintenance of OPD; infrastructure/ equipments /furniture's/ signage's etc. • Continuous monitoring and evaluation of OPD services with respect to its adequacy /efficacy includes following: ▪ Statistics of new and repeat visits on monthly and yearly basis. ▪ Percent changes in new and repeat visits over years in relation to availability of' doctors and registration staff. ▪ Fluctuation in visits by days of the week (or month) calculating average, high, low. ▪ Determine adequacy and utilization of clinics from clinic schedules of preceding year to current year, to decide on increasing or decreasing number of clinic /days etc. ▪ Monitoring of staff posted in OPD on regular basis. ▪ Monitoring and evaluation of pharmacy services. ▪ Monitoring and evaluation of other auxiliary services in OPD, such as minor OT, Injection room, registration services. ▪ Arrangement of drinking water. • Continuous collection of patient feedback (Through patient satisfaction surveys) and its analysis /evaluation and improvement. • Repair and maintenance of facility, equipments and instrument of OPD. • Regular condemnation. • Transfer of records to MRD and weeding of records as per Record Retention Schedule (RRS). • Maintenance of records, log books, inventory of consumables and non-consumable items efficiently. • Maintenance of daily roster. Punctuality and discipline among the staff posted in OPD and display of roster in a prominent location.	Sister I/C MRD/ Admin Administration. Sister I/C	
1.4.12 No Smoking Policy in OPD			
	• The whole hospital is a non smoking zone; Smoking is not permitted in any part of the Hospital. • No smoking instruction should be displayed prominently at multiple locations in OPD including toilets/ parking areas.	Hospital Administration	

1.4.13 Duty roster, punctuality, dress code and Identity for OPD staff			
	• All staff working in OPD should wear their Dress or apron as prescribed by hospital administration with a name plate of the staff. • All OPDs should start attending to patients by (9:00 AM) or as per schedule. • All doctors should sign and stamp / write their name in block letters in every prescription they write in OPD. • Registration counter should start at 8:30 AM sharp. • Registration counter of afternoon clinics should start at **2:00 PM** sharp. • Department wise duty roster of doctor should be available with I/C OPD before the start of week/ Month. **The nameplate with the name of the doctor, degree of the doctor and designation of the doctor should be displayed in front of each consultation room.** • All specialist/ resident/ nursing staff/ Paramedical staff/ security and sanitation staff should be punctual in their duty and start their work in time.		

FLOW CHART OPD



ANNEXURES

1.MEDICINE TRAY

	Content		**Content**		**Content**
1.	Inj. Oxytocin 10 IU	2.	Cap. Ampicillin 500 mg	3.	T. Metronidazole 400 mg
4.	T. Paracetamol	5.	T. Ibuprofen	6.	T. B-complex
7.	T. Misoprostol 200 mcg	8.	Inj. Gentamycin	9.	Inj. Vit K
10.	Inj.Betamethasone	11.	Ringer lactate	12.	Normal saline
13.	Inj. Hydrazaline	14.	Nifedipine	15.	T.Methyldopa
16.	Magnifying glass				

EMERGENCY TRAY (<u>ESSENTIAL TO KEEP AND UPDATED AND CHECKED DAILY)</u>

	Content		**Content**		**Content**
1.	Inj. Oxytocin 10 IU	2.	Inj. Magsulf 50%,20%	3.	Inj. Calcium gluconate 10%
4.	Inj. Dexamethasone	5.	Inj. Ampicillin	6.	Inj. Gentamycin
7.	Inj. Metronidazole	8.	Inj. Lignocaine 2%	9.	Inj. Adrenaline
10.	Inj. Hydrocortisone Succinate	11.	Inj. Diazepam	12.	Inj. Pheneramine maleate
13.	Inj. Carborost	14.	Inj. Pentazocine	15.	Inj. Phenergan
16.	Ringer lactate	17.	Normal saline	18.	Inj.Betamethasone
19.	Inj. Hydrazaline	20.	Nefidepine	21.	T.Methyldopa
22.	IV sets with two 16-guage needles	23.	Mouth gag	24.	Vials for drug collection
25.	IV Canula	26.	Inj. Ceftriaxone	27.	Controlled suction catheter

EXAMINATION TRAY

S. NO	CONTENTS
1.	Sim's speculum
2.	Cuscos speculum
3.	Anterior vaginal wall retractor
4.	Sponge holding forceps
5.	Allis / artery forceps

DRESSING / STITCH REMOVAL TRAY

S. NO	CONTENTS
1.	Scissors/ Blade
2.	Antiseptic solution
3.	Kidney tray
4.	Swabs
5.	Catheters
6.	Forceps
7.	Gloves
8.	Sterile linen

MINOR PROCEDURE TRAY (colposcopy/Cryo/Pap's smear)

S.NO.	CONTENTS
1.	Pap's smear spatula
2.	Antiseptic solution
3.	Speculum. (insulated/non insulated)
4.	Good Light source
5.	Gynae sheet

Annexure 2. FORM- F

[See Proviso to Section 4(3), Rule 9(4) and Rule 10(1A)]

FORM FOR MAINTENANCE OF RECORD IN RESPECT OF PREGNANT WOMAN BY GENETIC CLINIC/ULTRASOUND CLINIC/IMAGING CENTRE

1. Name and address of the Genetic Clinic/Ultrasound Clinic/Imaging Centre.
2. Registration No.
3. Patient's name and her age
4. Number of children with sex of each child
5. Husband's/Father's name
6. Full address with Tel. No., if any
7. Referred by (full name and address of Doctor(s)/Genetic Counseling Centre (Referral note to be preserved carefully with case papers)/self referral
8. Last menstrual period/weeks of pregnancy
9. History of genetic/medical disease in the family (specify)

Basis of diagnosis:(a) Clinical (b) Bio-chemical (c) Cytogenetic (d) Other (e.g. Radiological, ultrasonography etc. specify)

10. Indication for pre-natal diagnosis

A. Previous child/children with:

Chromosomal disorders	Metabolic disorders	Congenital anomaly	Single gene disorder
Mental retardation	Haemoglobinopathy	Sex linked disorders	Any other (specify)

B. Advanced maternal age (35 years)
C. Mother/father/sibling has genetic disease (specify)
D. Other (specify)

11. Procedures carried out (with name and registration No. of Gynaecologist/Radiologist/Registered Medical Practitioner) who performed it. …….. Non-Invasive

(i) Ultrasound …….. (Specify purpose for which ultrasound is to done during pregnancy)

[List of indications for ultrasonography of pregnant women are given in the important Notes]

Invasive

Amniocentesis	Chorionic Villi aspiration	Foetal biopsy
Cordocentesis	Any other (specify)	

12. Any complication of procedure – please specify
13. Laboratory tests recommended [Strike out whichever is not applicable or not necessary]

Chromosomal studies	Biochemical studies
Molecular studies	Preimplantation genetic diagnosis

14. Result of
    (a) Pre-natal diagnostic procedure (give details)…….
    (b) Ultrasonography Normal/Abnormal (Specify abnormality detected, if any).
15. Date(s) on which procedures carried out.
16. Date on which consent obtained. (In case of invasive)
17. The result of pre-natal diagnostic procedure was conveyed to ……..on ……
18. Was MTP advised/conducted?
19. Date on which MTP carried out.

Date: Name, Signature and Registration number of the
Place Gynaecologist/Radiologist/Director of the Clinic

DECLARATION OF PREGNANT WOMAN

I, Ms._____(name of the pregnant woman) declare that by undergoing ultrasonography/image scanning etc. I do not want to know the sex of my foetus.

Signature/Thump impression of pregnant woman

DECLARATON OF DOCTOR/PERSON CONDUCTING ULTRASONOGRAPHY/IMAGE SCANNING

I,_____(name of the person conducting Ultrasonography/image scanning) declare that while conducting ultrasonography/image scanning on Ms.___(name of the pregnant woman), I have neither detected nor disclosed the sex of her foetus to any body in any manner.

Name and signature of the person conducting Ultrasonography/image scanning/ Director or owner of genetic clinic/ ultrasound clinic/imaging centre

Important Notes are given in back side P.T.O

Important Note:-

(i) Ultrasound is not indicated/advised/performed to determine the sex of foetus except for diagnosis of sex-linked diseases such as Duchenne Muscular Dystrophy, Haemophilia A & B etc.

(ii) During pregnancy Ultrasonography should only be performed when indicated. The following is the representative list of indications for ultrasound during pregnancy.

(1) To diagnose intra-uterine and/or ectopic pregnancy and confirm viability.

(2) Estimation of gestational age (dating).

(3) Detection of number of fetuses and their chorionicity.

(4) Suspected pregnancy with IUCD in-situ or suspected pregnancy following contraceptive failure/MTP failure.

(5) Vaginal bleeding / leaking.

(6) Follow-up of cases of abortion.

(7) Assessment of cervical canal and diameter of internal os.

(8) Discrepancy between uterine size and period of amenorrhoea.

(9) Any suspected adenexal or uterine pathology / abnormality.

(10) Detection of chromosomal abnormalities, foetal structural defects and other abnormalities and their follow-up.

(11) To evaluate foetal presentation and position.

(12) Assessment of liquor amnii.

(13) Preterm labour / preterm premature rupture of membranes.

(14) Evaluation of placental position, thickness, grading and abnormalities (placenta praevia, retroplacental haemorrhage, abnormal adherence etc.).

(15) Evaluation of umbilical cord – presentation, insertion, nuchal encirclement, number of vessels and presence of true knot.

(16) Evaluation of previous Caesarean Section scars.

(17) Evaluation of foetal growth parameters, foetal weight and foetal well being.

(18) Colour flow mapping and duplex Doppler studies.

(19) Ultrasound guided procedures such as medical termination of pregnancy, external cephalic version etc. and their follow-up.

(20) Adjunct to diagnostic and therapeutic invasive interventions such as chorionic villus sampling (CVS), amniocenteses, foetal blood sampling, foetal skin biopsy, amnio- infusion, intrauterine infusion, placement of shunts etc.

(21) Observation of intra-partum events.

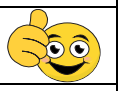
(22) Medical/surgical conditions complicating pregnancy.

(23) Research/scientific studies in recognized institutions.

Person conducting ultrasonography on pregnant women shall keep complete record thereof in the clinic/centre in Form – F and any deficiency or inaccuracy found therein shall amount to contravention of provisions of section 5 or section 6 of the Act, unless contrary is proved by the person conducting such ultrasonography.

Annexure 3 .OPD FEEDBACK Form

ओ0पी0डी0 रोगी फीडबैक फॉर्म

	सूचक	निम्न स्तरीय 	सामान्य 	अच्छा 	बहुत अच्छा 
1	अस्पताल में विभिन्न सेवाओं/विभागों तक पहुँचने के लिए सूचना बोर्ड का यथाचित **प्रदर्शन**				
2	पंजीकरण कराने में कुल समय	30 मिनट से ज्यदा	11–30 मिनट	5–10 मिनट	5 मिनट मे
3	**रजिस्ट्रेशन** काउंटर में अस्पताल के कर्मचारियों का व्यवहार				
4	प्रतिक्षा कक्ष में बैठने की सुविधा तथा पंखों की उपलब्धता				
5	ओ0पी0डी0 में पीने के पानी की सुविधा				
6	ओ0पी0डी0 में स्वच्छ **शौचालय** की सुविधा				
7	पंजीकरण के बाद डॉक्टर को दिखाने में लगा समय				
8	डॉक्टरों द्वारा मरीज के साथ व्यवहार				
9	डाक्टर द्वारा मरीज की जांच/**परामर्श**, सलाह में दिया गया समय				
10	अस्पताल में जांच : लेब जांच एक्सरे इत्यादि की उपलब्धता				
11	दवाखाने में कार्यरत कर्मचारियों का व्यवहार				
12	दवाखाना में दवाई की उपलब्धता				
13	डॉक्टर को दिखाने के **पश्चात्** दवा लेने में लगा कुल समय				
14	अस्पताल में दिये गये उपचार व सेवाओं से संतुष्टि				

1 आप इस अस्पताल व इसकी सेवाओं में क्या सुधार चाहतें हैं

2 इसी अस्पताल में ईलाज के लिए आने का कारण

3 क्या आप इलाज के लिए इस अस्पताल की सेवाओं को पुनः प्राप्त करना चाहेंगे

4 आपका बहुमूल्य सुझाव

दिनांकः आयुः लिंगः पुरूष/महिला ओ0पी0डी0 नम्बर

2. OBSTETRICS & GYNAECOLOGY- IN-PATIENT DEPARTMENT.

2.1 Purpose:

Purpose of this SOP is to ensure that all patients are provided with evidence based quality care in an environment of minimal risk, covering every aspect of patient care from the time patient is received in the gynecology ward through diagnosis, treatment, discharge of the patient from the hospital and follow-up.

2.2 Scope:

This SOP covers all the processes and guidelines to be followed by all doctors, nurses, paramedical and other support staff involved in the management of the patients in the gynecology ward, and management of the ward including provision of requisite specific care, medication, nutrition, care during pre and post-operative period, transfer, cross referrals/ consultation/discharge/ and end of life care. Management of ward includes inventories, cleanliness, record keeping, ward rounds, duty rosters, and security management.

2.3 Responsibility:

The tasks are divided in a practical manner among the doctors and staff posted in the gynecology ward (IPD).

2.4 Procedure:

S.No.	ACTIVITY	RESPONSIBILITY	REFERENCE
2.4.1 Receiving and initial assessment of the patient.			
A.	**Receiving of the patient**: Patient is received in ward after admission is done at the patient admission counter of the hospital. Patient is provided with a admission slip bearing a centralized registration number (C.R. No.)	Nursing Staff	
B.	**Documentation** and entry of personal details of the patient in Records. (IPD admission register).	Nursing Staff	IPD Admission register
C.	**Initial Assessment:** • A quick assessment of the patient is to be done in a designated examination area in complete privacy. • A provisional diagnosis is made and the patient is classified as low risk or high risk category depending on the basis of condition of the patient or expected outcomes.	Doctor on Duty	

D.	**Diagnosis:** Depending on the facilities available at the hospital (with respect to equipments/competencies/ availability of other requisite services, I. **High Risk Patient:** is either shifted to: • HDU/ICU/ward after counseling and documentation of the prognosis, wherever facilities are available. • In case of unavailability of any of the critical facilities required for the management of patient, such patient should be counseled and transferred to higher center as per the transfer policy of the hospital II. **Low Risk Patients: a**re patients who are low risk for complications (as per the initial assessment) & they are provided bed with clean linen, diet.	Doctor on Duty	

2.4.2 Admission, shifting and referral of patients.			
A.	**Patient Transfer Protocol:** • Every Hospital should have their own patient transfer protocol/ (SOP). • There must be reasonable ground for transfer of patient. (grounds must be recorded in the transfer summary). • No patient should be transferred without transfer summary (referral slip For ambulatory and stable patient) • Patient's relatives to be informed and explained about the condition and reasons of transfer as soon as the decision of transfer has been taken. • No hemodynamically unstable patients should be transferred; every effort should be made to stabilize the patient before transferring. • If it is not possible to stabilize the patient, such patients are to be transferred in an adequately equipped ambulance and available trained staff.	Staff nurse/doctor on duty	

	• It must be for the benefit of the patients. • Consultant must be informed about transferring the patient. • There should be a hospital policy for transferring the patient, with respect to ambulance / doctor and paramedic to accompany the patient. • A record of all transfers to be maintained at department level.(patient transfer register) • Transfer summary must contain: o History, Clinical examination, Investigation reports if any, ECG, X-Ray, USG reports, treatment provided. o Reasons for transfer. o What is required, is not available in the transferring hospital. o Whether a formal call to the referral hospital was made, if yes, it should also be recorded in the summary. o If for any reason, if it was not possible to contact the referral hospital reasons for the same should also be recorded. o Transfer summary must contain legible name and designation of the transferring doctor. • For EWS patient transfer the guidelines issued by DHS are to be followed. • In case a low risk / manageable patient or their relative wants a transfer, against the advice of doctor it should be recorded in the case sheet and on the discharge summary along with the signatures of the patients / his/ her relatives.		

2.4.3 Requisition of diagnosis and receiving of reports.			
A.	• Requisite laboratory investigations, ECG, USG, X-Ray are to be prescribed in the patient's case sheet and investigation forms are to be duly filled. • Sample is collected and labeled properly for lab investigations, and for imaging investigation and ECG, patient may be required to be taken to that department. • Low risk patient is taken to radiology	Doctor on duty Staff nurse/Doctor on duty Nursing orderly Staff nurse	

	department along with N.O and for high risk patients a bed side imaging/ ECG should be arranged where feasible or patient may be taken to the department accompanied by a doctor. • Reports are to be collected from the lab / Radiology department and placed in the patients file, and concerned doctor to be informed about the receipt of the reports.		
2.4.4 Preparation of patient for surgical procedure			
A.	**Informed consent for surgical procedure:**		
	• Informed consent for surgical procedure is a process in which the patient is informed of the indications for the surgery, the possible risks, the possible benefits, the alternatives, and the possible consequences of not getting the surgery done. • Informed consent may be obtained by a doctor, a nurse, who is knowledgeable about surgical procedure and the patient's condition so as to be able to explain the elements of informed consent above. • A written informed consent is taken, duly signed by the patient and/or her immediate relative and doctor.	Doctor on Duty/Staff nurse	
B.	**Patient preparation:**Patient is prepared as per the orders of the surgeon and anesthetist, including • Pre-operative investigation: CBC,LFT, KFT, BS –Fasting &PP,CXR, USG, ECG, coagulation profile. • Screening for HBV, HCV and HIV is also desirable. • Medication for optimal control of underlying medical disorder. • Bath one night prior to surgery. • Grouping and arrangement of blood, pre-op blood transfusion • Nil P.O (4-6 hrs fasting) • Site preparation/clippingEnema/bowel preparation. • Site marking • Any special instruction of anesthetist given at the time of pre anesthetic checkup. • Pre –operative medications/ including antibiotic as prescribed.	Nursing staff Doctor on Duty	

	• Enlist the Patient for O.T. list and inform the concerned surgeon and anesthetist. • Enlisted patients are provided with OT clothes on the day of surgery and shifted to O.R on wheel chair or trolley at least half an hour before scheduled surgery. • The patient is handed over to the O.T staff.	Nursing staff/ nursing orderly	
C.	**Post-Operative:** • The patient is received in ward by nurse on duty after the procedure. • Nurse calls the doctor on duty to assess the condition of the patient and to check the completeness of post-operative notes including medication.	Nursing staff + Doctor on Duty	
D.	**Daily Ward Rounds:** • There should be at least two rounds in the ward to be taken in the morning and evening. • Morning rounds to be taken by Unit In-charge along with the IPD team and evening round by DOD.	Unit In-charge/ Doctor on Duty/ Staff nurse	
2.4.5 Transfusion of blood			
A	**PRE-REQUISITE FOR B.T** • A doctor's order on the patient case sheet is must for transfusion. • Quantity of blood/component and rate of transfusion must also be prescribed in the case sheet.		
B.	**Informed consent for blood transfusion:** • The patient is informed of the medical indications for the transfusion, the possible risks, the possible benefits, the alternatives, and the possible consequences of not receiving the transfusion. • Consent should be obtained sufficiently in advance of the transfusion that the patient can truly understand what is said and have sufficient time to make a choice, whenever feasible. • Consent should be documented duly signed by patient/ relative/ doctor/nurse • A single informed consent may cover many transfusions if they are part of a single course of treatment. • It may be advisable, though, to **obtain a new consent when there is a significant**		

	change in the patient's care status, such as a transfer for care to another service, an inpatient admission, or an outpatient transfusion. • In **emergency situations** the physician ordering the transfusion must make a reasonable judgment that the patient would accept the transfusion. Transfusion should not be delayed in a life-threatening situation if it is likely that the patient would agree to transfusion. After the event, the circumstances of the transfusion decision should be documented in the case sheet of the patient.		
C	• Blood sample of the patient is sent to the blood bank for grouping and cross matching, along with blood requisition form (should clearly mention name of the required product and number of units required). (sample labels, blood requisition form checked and matched with the patients file) • Availability of requisite product is to be ascertained from blood bank. • If blood is required later, blood bank should be informed and asked to keep the cross matched blood reserved for the patient till such time. • If it is urgent and life saving, it should be clearly mentioned in the requisition form. • A blood release form is sent to the blood bank, one bag at a time, if no storage facility is available in house, If there is a facility for storage, (Blood bank refrigerator is available) the total quantity of the required blood is to be released from the blood bank.		**Annexure 1 of SOP Maternity ward -** Checklist for Blood Requisition Form
D.	**Receive the blood and verify that:** • Blood is designated for a patient for whom requisition was sent. • Release form bears all the details along with the signature of blood bank staff. • Name and CR number recorded on the release form attached to the unit correspond with that of the intended Patient. • Check, ABO Rh type, patient name/ CR No./ blood bag no and date of expiry of the		

	blood or component. • Unit has a normal appearance and is cold. In case of any discrepancy inform the blood bank immediately, do not transfuse till everything has been clarified from the blood bank. • Record the date and time of receipt of blood bag in the ward on the blood bank release form. • Check the patient case sheet for transfusion order, type, volume and rate of transfusion. • Check if any pre medication is prescribed. Medicate the patient accordingly. • Verify the patient's name & CR No, blood bag for component type/ group/ expiry date. • Check, and record the patient's blood pressure, pulse, respirations and temperature in the chart or on the case sheet with date and time of starting transfusion. • Immediately before transfusion, mix the unit of blood thoroughly by gentle inversion. • If rapid and large volume transfusion is required, a blood warmer can be used if available.		
E.	**Start transfusion if everything is in order:** • Initial flow rate should be slow not more than 1 ml/minute to allow for recognition of an acute adverse reaction. Proportionately smaller volume for pediatric patients. • If no reaction occurs for first 15 minutes increase the rate to 4 ml / min. usual transfusion time is 2-4 hours, and it should not exceed 4 hours for any component. • Platelets, plasma and cryoprecipitate: 10 mL per minute. The transfusion may be administered as rapidly as the patient can tolerate, usually 30 minutes. • During transfusion, monitor the vitals of the patient every 30 minutes (PR, BP, RR, Spo2, Temp and any sign of urticaria) • Access the flow rate; if unusually slow (less than 3 ml/Min. consider the following to		**Annexure 2 of SOP Maternity Ward-** Checklist for before starting Blood Transfussion

	enhance the flow rate. • repositioning the patient's arm, • changing to a larger gauge needle, • changing the filter and tubing, • elevating the IV pole. • Consider using a transfusion pump if available		
F.	**Signs of blood transfusion reaction:** • **Hives and itching: a**re non serious reactions generally controlled by antihistaminic/ steroid and slow the rate of infusion. • **Isolated fever;** Developing a fever after a transfusion is not serious. A fever is body's response to the white blood cells in the transfused blood. (slow the rate of infusion.) • However, it can be a sign of a serious reaction if the patient is also experiencing nausea vomiting, back or chest pain ,dark colored urine STOP TRANSFUSION IMMEDIATELY AND INFORM THE BLOOD BANK AND TREATING DOCTOR. If a transfusion reaction is suspected • Stop the transfusion • Maintain the IV with normal saline. • Save the bag and attached tubing, send it to the blood bank for investigation.		**Annexure 3 of Maternity SOP-** Checklist in case of Blood Transfusion Reaction
	In case of uncomplicated transfusion. • Record date and time when transfusion was stopped. • volume of blood infused. • Documenting the presence/absence of a transfusion reaction in the patient case sheet. • Discard the blood bag and tubing as per BMW guidelines. • Outpatients or patients who will be leaving the hospital within one week of transfusion should be given written instructions regarding delayed transfusion reactions and asked to report immediately		

2.4.6 Maintenance of rights and dignity of the patient			
	• Maintenance of women's rights, dignity, privacy and confidentiality is responsibility of every doctor and staff involved in the care of the patient. • Patient's right and responsibilities should be displayed in local language in all patient waiting areas and wards. • Social workers and nurses should also educate the patients about their right and responsibilities. • All doctors and paramedical staff should be made aware of the right and responsibilities of the patients..		
A. A.1 A.2 A.3	**Patients rights:** **Care**: • Patients have a right to receive treatment irrespective of their demographic profile. • Right to be heard regarding her concerns. **Confidentiality and Dignity:** • Right to personal dignity and to receive care without any form of stigma and discrimination. • Privacy during examination and treatment. • Protection from physical abuse and neglect. • Accommodating and respecting their special needs such as spiritual and cultural preferences. • Right to confidentiality about their medical condition. **Information:** The information to be provided to patients is meant to be **preferably** in a language of patient's preference and in a manner that is effortless to understand. • Patients and/ or their family members have the right to receive complete information on the medical problem, prescription, treatment & procedure details. • A documented procedure for obtaining		

	patient's and / or their family's informed consent exists to enable them to make an informed decision about their care. • Patients have to be educated on • risks, benefits, expected treatment outcomes and possible complications to enable them to make informed decisions, and involve them in the care planning and delivery process. • Patients or their authorized individuals have the right of access and to get a copy of their clinical records on their written request.		
A 4.	**Preferences:** • Patients have a right to seek a second opinion on their medical condition. • Right to information from the doctor to provide the patient with treatment options, so that the patient can select what works best for her.		
B.	**Patients responsibility**:		
B.1	Honesty in disclosure: • Patients shall be honest with doctor & disclose their complete family/ medical history whenever asked.		
B.2	Treatment compliance: • Patients shall do their best to comply with doctor's treatment plan. • Patients shall have realistic expectations from the doctor and his/her treatment. • Inform and bring to the doctor's notice if it has been difficult to understand any part of the treatment or of the existences of challenges in complying with the treatment.		
B.3	Transparency and honesty: • Patients shall make a sincere effort to understand their therapies which include the medicines prescribed and their associated adverse effects and other compliances for effective treatment outcomes. • If not happy, patient shall inform and discuss with her doctor/		

B.4	administration. • Patients shall report any fraud and wrong doing by any staff member or person in the hospital. Conduct: • Patients shall be respecting the doctors and medical staff. • Patients shall abide by the hospital / facility rules.		
2.4.7 Record maintenance including taking consent.			
A.	**Record maintenance in ward:** • A record index should be available in every ward and it should contain: o List of all forms o List of all registers • Management of patient's case sheet. o A separate file is created for every patient admitted to ward. o The cover of the file must contain CR No. / Name/Age / Sex/ and bed number of the patient. o Following forms and documents are to be kept in patient's file in chronological order. o Admission form/ registration forms of the patient. o Clinical notes/ treatment sheets/ progress notes. o Investigation reports o O.T notes o Blood Transfusion notes o Interdepartmental consultation/ referral records. o Discharge/transfer/ death summary of the patient. • The completed records (case sheet of the patient is transferred to MRD after discharge death and transfer of the patient.) • While transferring the records to MRD, nursing staff must verify the record is complete in every respect and documents are duly signed by respective doctor on the front sheet. **Management of ward registers:** • All important registers such as admission		

	register, birth/ death register, daily census register etc. are to be transferred to MRD after their completion. • Rest of registers such as treatment book, injection register, lab register etc to be retained and weeded as per the record retention schedule of the Hospital.		
B.	**Taking informed consent of patient:** • Informed consent to be taken apart from general form of authorization for medical and surgical management. • Informed concerned is taken for all surgical procedure, blood transfusion, invasive procedure, high risk medications etc. • **Process for taking informed consent.** o Before any of the above procedure, patient and their relatives are informed about the planned procedure in a language they can understand easily. o Preferably in presence of a staff nurse. o They are explained in detail about the procedure its benefits, risk and available alternatives. o Also explained the risks and complications that may arise on refusing the planned procedure. o All queries of patient and their relatives are to be answered to their need and satisfaction. o After the counseling is complete and patient /and or their relative agree, the informed consent is prepared, read aloud to the patient and then get it signed by patient, relative , Nurse and doctor.		
2.4.8 Counseling of the patient at the time of discharge.			
A	**Discharge of patient from ward:** As soon as decision of discharge is taken on account of cure/ or improvement or patient willfully wants to get discharged against advise. Before a discharge summary is issued to the patient leaving the ward:		
A.1	**A pre discharge counseling is done for every patient to explain the :**		

	• Current condition and the prognosis. It is to be done by senior staff nurse or consultants. • Instruction and what to do in a case of emergency. • Instruction for follow up visits, with days, date/ room number. • Medications and precautions if any. • Do's and don't's • Referrals after discharge if required (such as for management of other medical/ surgical disorder). • Obtain a patient feedback regarding quality of services.		
B.	**Discharge summary must contain the following:** • DOA & DOD • Personal detail of the patient • Diagnosis • Investigations with reports /results. • Pre-op, Operative note and post-op notes. • Treatment/intervention/ medications provided during the stay. • Advise on discharge: should also include, Medicines, precautions, any special instruction • Instructions for follow-up visits.(with day date and timing.		**Annexure 4 of SOP Maternity ward -** IPD feedback form in Hindi From
C.	**Death of Patient in Ward:** • Doctor on duty should be present at the bed side in case of dying patient along with other paramedical staff. • Doctor will pronounce the patient as dead. • Information must be given clearly to the relatives of the patient **<u>by</u>** doctor or nursing staff. • Autopsy to be offered wherever indicated • Death report to be given only after lapse of an hour of pronouncing death • Patient to be covered and cornered in a dignified way , body should be cleaned, chin should be tied, and eye should be closed, and wrapped in mortuary sheet. • Two tag one around neck and one around wrist is tied in case body is to be kept in		

	mortuary, bearing details of the patient along with date and time of death. • Body to be handed over to the relative after all requisite documentation along with a death summary stating the cause of death. • Nodal Officer MDRC(maternal death review committee) to be informed immediately. • Facility based format as per maternal death review to be filled up and submitted to nodal officer.		
2.4.9 Environment cleaning , infection control and processing of equipment			
	These include the following: A. Hand washing and antisepsis (hand hygiene); B. Use of personal protective equipment when handling blood, body substances, excretions and secretions; C. Appropriate handling of patient care equipment and soiled linen; D. Prevention of needle stick/sharp injuries; E. Environmental cleaning(cleaning of surfaces) and spills-management; and F. Appropriate handling of waste (as per biomedical waste management handling rules).		
A.1 A.2	**Wash or decontaminate hands:** • After handling any blood, body fluids, secretions, excretions and contaminated items; • Between contact with different patients; • Between tasks and procedures on the same patient to prevent cross contamination between different body sites; • Immediately after removing gloves. **Antimicrobial soap:** Used for hand washing as well as hand antisepsis. • If bar soaps are used, use small bars and soap racks, which drain. • Do not allow bar soap to sit in a pool of water as it encourages the growth of some		

A.3	micro-organisms such as pseudomonas. • Clean dispensers of liquid soap thoroughly every day. • When liquid soap containers are empty they must be discarded, not refilled with soap solution. **Specific antiseptics recommended for hand antisepsis:** • 2%-4% chlorhexidine, • 5%-7.5% povidone iodine, • 1% triclosan, or • 70% alcoholic hand rubs. • Waterless, alcohol-based hand rubs: with antiseptic and emollient gel and alcohol swabs, which can be applied to clean hands. • Dispensers for hand rub should be placed outside each patient room.		
B.	**Use of personal protective equipment** • Health care workers who provide direct care to patients and who work in situations where they may have contact with blood, body fluids, excretions or secretions; • support staff including medical aides, cleaners, and laundry staff in situations where they may have contact with blood, body fluids, secretions and excretions • Personal protective equipment includes: • Gloves • Protective eye wear (goggles) • Mask • Apron • Gown • Boots/shoe covers • Cap/hair cover. • After use discard the used personal protective equipment in appropriate disposal bags, and dispose of as per the BMW policy of the hospital. • Do not share personal protective equipment. • Change personal protective equipment completely and thoroughly wash hands each time you leave a patient to attend to another patient or another duty.		

C.	**Appropriate handling of patient care, equipment handling and soiled linen.**		
C.1	• Handle patient care equipment soiled with blood, body fluids secretions or excretions with care in order to prevent exposure to skin and mucous membranes, clothing and the environment. • Ensure all reusable equipment is cleaned and reprocessed appropriately before being used on another patient. • Mattresses with plastic covers should be wiped over with a neutral detergent. • Mattresses without plastic covers should be steam cleaned if they have been contaminated with body fluids. • If this is not possible to decontaminate the bedding it should be removed by manual washing, ensuring adequate personnel and environmental protection.		
C.2	**Linen Handling:** • Place used linen in appropriate bags at the point of generation. • Contain linen soiled with body substances or other fluids within suitable impermeable bags and close the bags securely for transportation to avoid any spills or drips of blood, body fluids, secretions or excretions. to be stored and transported in a leak proof container. • Do not rinse or sort linen in patient care areas (sort in appropriate areas). • Handle all linen with minimum agitation to avoid aerosolization of pathogenic micro-organisms • Separate clean from soiled linen and transport/store them separately. • Transport and process used linen, and linen that is soiled with blood, body fluids, secretions or excretions with care to ensure that there is no leaking of fluid.		

D.	**Prevention of needle stick/sharps injuries** • Take care to prevent injuries when using needles, scalpels and other sharp instruments or equipment. • Place used disposable syringes and needles, scalpel blades and other sharp items in a puncture-resistant container with a lid that closes and is located close to the area in which the item is used. • Take extra care when cleaning sharp reusable instruments or equipment. • Never recap or bend needles. • Sharps must be appropriately disinfected and/or destroyed as per the national standards or guidelines.		

E.	**Environmental cleaning(cleaning of surfaces) and spills-management:** • Ward along with all equipments and all surfaces should be cleaned every morning. • All toilets to be cleaned using surface disinfectant at the start of every shift. • The floor and sink should be cleaned with detergent soap at the start of every shift. • Mopping of floors (at the start of every shift/ and sos for spillage). Procedure for mopping described as under. o Clean water is taken in three bucket numbered 1, 2 and 3. o Surface disinfectant is added in bucket no-3,(so that 1st and 2nd bucket has clean water and third bucket has disinfectant). o Cleaning of floor begins from inside to outside. Towards the end all corner and groves to be cleaned. o After each sweep of the floor the mop should be dipped first in bucket no. 1, then in no.2 and lastly in no-3 and then floor is mopped again. This process is repeated till the whole area is cleaned. o Water of the three containers to be changed (depending on the size of the ward) as the water in 3rd bucket gets		

	dirty. o Mops to be cleaned in dirty utility area and put in a stand under sun with head of the mop upward, and mops should not be left wet in the ward or any patient area. o After mopping blood or body fluids the mop should be treated as soiled linen and discarded as per BMW guidelines. o Mops should be visibly clean before starting cleaning of a ward • Handle patient care equipment soiled with blood, body fluids secretions or excretions with care in order to prevent exposure to skin and mucous membranes, clothing and the environment. • Ensure all reusable equipment is cleaned and reprocessed appropriately before being used on another patient. • Universal safety guideline to be followed by all staff members working in the ward.		
F.	**Handling of general and biomedical waste in wards:** To be done as per the biomedical waste management and handling rules.		
2.4.10 Sorting and distribution of clean linen to the patients.			
A.	• The clean bedding and clean clothes installs psychological confidence in the patients and the public and enhances their faith in the services rendered by the hospital. • Every effort should be made to provide clean and tidy linen to the patients. • Linen management in ward has following components. o Maintenance of Stock of clean linen. o Sorting and distribution of clean linen. o Handling of dirty linen o Managing laundry services.	Nursing Staff	
B.	**Maintenance of stock of clean linen.** • Adequate stocks of clean linen to be maintained in ward.	Nursing Staff	

	• Quantity to be calculated on the basis of daily requirement, laundry turn over time and 20% of buffer stock to be added. Calculated as under: • STOCK= Daily requirement X Laundry turnover days. • Laundry turn over days is number of days laundry takes to clean and return clothes to the ward. • Add 25% to above for buffer and rainy days. • EXAMPLE (calculation for stock of bed sheet to be kept in ward): for a 25 bedded ward , where laundry takes 7 days to return the clothes. • Daily requirement = Number of bed (25) X 7= 175 • Add 25 % = 43.75 (round it to 44) • Stock of bed sheet to be kept in a 25 bedded ward is approximately 219. Similarly a stock of other linen items to be calculated and kept in stock. • Torn and stained clothes to be sorted and condemned as per hospital policy or if possible stitched time to time as per requirement. • Life of linen depends on the quality of fabric, washing methods. • Following quantity of linen is suggested for wards in general. o Bed sheets – 6 -8 per bed. o Pillow cover – 4-6 per bed. o Pillow 2 per bed o Blanket - 3-4 per bed o towel - 2 per bed o draw sheet -6-8 per bed o patient dress 4 pairs o duster 20 per ward o Mortuary sheet 6/ward o Baby sheet 10 per bed. o Mattress cover 2 per bed Note: above requirement is indicative only, requirement can very as per availability of laundry in house, demand /stock to be calculated for individually for every ward .		
C.	**Sorting of laundry:** Linen for laundry to be sorted and kept in separate bags at the point of generation.	Nursing Staff	

	• **Soiled linen:** are used by patient/ ordinary dirty without urine etc. are collected at source and send for washing (no sorting at source required , minimal storage at source) • **Infected linen:** Linen soiled with pus blood, body discharge, Minimum storage at source, sluicing and soaking in disinfectant solution to be done in laundry. • **Foul linen:** Faeces, excretions and blood stained linen to be collected in leak proof containers, and sluicing to be done before washing.		
D.	• Clean linen is distributed daily during the first shift in the ward. (bed sheets, pillow cover etc require daily change. • Also change linen as and when soiled/ stained. • Patients should be provided with clean and unstained linen. • Torn linen are repaired or discarded immediately, should not be provided to the patients.	Nursing Staff	
2.4.11	**End of life care**		
	A. Recognizing when a person may be in the last days of life B. Communication C. Shared decision-making D. Maintaining hydration E. Pharmacological interventions F. Anticipatory prescribing.		Nice guidelines
A.	**Recognizing when a person may be in the last days of life:** • If it is thought that a person may be entering the last days of life, gather and document information on: • The person's physiological, psychological, social and spiritual needs • Current clinical signs and symptoms • Medical history and the clinical context, including underlying diagnoses		

	• The person's goals and wishes. • The views of those important to the person about future care.		
B.	**Communication:** • Assess the mental and psychological condition of the patient by talking to the patient and their close relative. • Identify the most appropriate person or team to explain the dying person's prognosis to the patient or their close relatives. Discuss about the available alternatives for the condition. • Try to find out the cultural, religious, social and spiritual needs and preferences of the patient and family, also whether the dying person has understood and can retain information given about their prognosis. • Provide accurate information about their prognosis (unless they do not wish to be informed) explain any uncertainty and how this will be managed, avoid false optimism, and record this in the patient's case sheet. • Talk about the fears, anxieties and concerns of the patient and or the family members and provide them the required information if any. • Inform the patient and family how to contact members of the care team when required. • Provide them information on home care of the patient.		
C.	**Shared decision making :** • The clinical care team should help the patient and his family in making decisions regarding care and other social, cultural, religious or spiritual requirements/ needs. • Try to provide individualized care to the patient as per their need and wishes. • Provide information about the care plan of the patient discuss it the patient and their relative and try to take a shared decision on the care of the patient.		
D.	**Hydration** • Support the dying person to drink if they wish to and are able to without any risk of aspiration.		

	• Encourage / educate relatives of the dying person to help with mouth and lip care or giving drinks, if they wish to. Provide any necessary aids and give them advice on giving drinks safely. • Assess, preferably daily, the dying person's hydration status, and review the possible need for starting clinically assisted hydration, respecting the person's wishes and preferences. • Discuss the risks and benefits of clinically assisted hydration with the dying person and/ or their relatives. • Consider a therapeutic trial of clinically assisted hydration if the person has distressing symptoms or signs that could be associated with dehydration, such as thirst or delirium, and oral hydration is inadequate. • For people being started on clinically assisted hydration: o Monitor at least every 12 hours for changes in the symptoms or signs of dehydration, and for any evidence of benefit or harm. o Continue with clinically assisted hydration if there are signs of clinical benefit. o Reduce or stop clinically assisted hydration if there are signs of possible harm to the dying person, such as fluid overload, or if they no longer want it. • Review the risks and benefits of continuing clinically assisted hydration with the person and those important to them.		
E.	**Pharmacological interventions:** Providing appropriate non-pharmacological methods of symptom management is an important part of high quality care at the end of life, for example, re-positioning to manage pain or using fans to minimize the impact of breathlessness. However drugs must be provided to control or relieve the patient from: • Pain • Nausea and vomiting		

	• Breathlessness • Anxiety, delirium and agitation. • Noisy respiratory secretions.		
F.	Anticipatory medicines can also be prescribed for control of any of the above symptoms before they occur.		

3 - LABOUR ROOM

3.1 Purpose:

To ensure that all patients in labour room are provided with evidence based quality care in an environment of minimal risk, covering every aspect of patient care from the time patient is received to discharge of the patient.

3.2 Scope:

This SOP covers all the processes and guidelines to be followed by all doctors (Obstetrician & Neonatologist), nurses, paramedical and other support staff involved in the management of the patient in the LR, cross referrals/ consultation, transfer inclusive of essential newborn care.

3.3 Responsibility:

There is a division of tasks and they are divided in a practical manner among the doctors and staff posted in the LR (the labour room team). Individual hospital can divide the task further among available staff depending upon skills and competencies.

3.3 Procedure:

Sr. No.	Activity/Description	Responsibility	Ref. Doc./Record
3.3.1 Receiving and Assessment of the Patient of Delivery			
A.	**Receiving of the patient**: The patient is received in the LR after getting admitted from OPD, casualty or can be transferred from the maternity ward.	Nursing Staff	
B.	**Documentation** and entry of personal details of the patient is done in LR records.	Nursing Staff	
C.	**Initial Assessment:** • A quick assessment of the patient is to be done in a designated examination room / area in complete privacy. (including assessment of vitals- PR, RR, BP, Temp, SPo2 and PV examination) • A provisional diagnosis is made as soon as possible following admission in labour room by abdominal palpation and vaginal examination. • Classify the case as 'low risk' or 'high risk' category depending upon the condition and expected outcomes/ complications.	Doctor on Duty Nursing Staff Doctor on Duty	.

	• Document whether - Not in labor - Early Labor - Active Labor >4cm - Abortion • Provide clean linen and bed. • Take consents, counsel the relatives regarding the present situation, and further course of action.		
3.3.2 Emergency Obstetric Care			
A.	All obstetric emergencies should be managed in HDU/ ICU of labour room where available, a decision to transfer the patient must be taken if facilities are not available and as per the transfer protocol of the hospital. **Antepartum Haemorrhage(APH):** • Antepartum Haemorrhage (vaginal bleeding after 20 weeks of pregnancy) is a life threatening condition both for mother and the foetus. It requires urgent action for optimal feto-maternal outcome. • History is taken along with the assessment of the maternal vital parameters (pallor, pulse, RR, BP, SpO2) and per abdomen examination for uterine tone and foetal condition. • Simultaneous resuscitation of patient depending on her general condition is done. Insert IV cannula, No. 16 .Blood samples are taken for investigations: CBC, coagulation profile, blood group and cross matching. • Counseling of the patient and relatives done regarding the seriousness of the condition, need for caesarean section, blood transfusions, and emergency hysterectomy. Consent for the same is taken. • Patient is monitored for vital parameters, bleeding PV, urine output. • USG is done to confirm the diagnosis. • **Placenta Previa**- no PV is done. If bleeding PV uncontrolled- emergency caesarean section is done. • **Abruptio placentae** -ARM & oxytocin or caesarean section as per need. If patient is in DIC- the cause is treated and blood component therapy given.	Senior Resident, Consultant	See patient transfer protocol. 4.10 B
B.	**Postpartum Hemorrhage (PPH):** Postpartum hemorrhage is defined as the blood		

	loss after delivery of baby in excess of 500 ml after vaginal birth, 1000 ml after cesarean section. However, clinically any amount of bleeding from the genital tract following the birth of the baby which adversely affects the general condition of the mother is termed as PPH. • Call for help, alert nursing staff, obstetrician and anesthetist • Resuscitate, monitor and take measures to arrest bleeding at the same time • **Resuscitate :** ▪ Patient is kept warm and head end lowered ▪ Oxygen given by mask. ▪ Two IV cannula (16 or 18 G) inserted ▪ Blood samples taken for: haemogram, PT, APTT, blood grouping and cross matching, electrolytes. ▪ Catheterization of bladder is done ▪ Crystalloids (up to 2 L) are rapidly infused until blood arrives **If Bleeding continues.....** Explore uterus to ensure it is empty **I. Atonic uterus** • Bimanual massage is done • Oxytocin infusion is started (20 IU in 1000 ml of normal saline @ 60 drops per minute). • Once bleeding is controlled: Oxytocin infusion is reduced to 40 drops per minute. (maximum 3 liters of oxytocin infusion can be given). • Intravenous bolus of oxytocin should not be given as it may lead to hypotension. • Methyl-ergometrine- IM or IV slowly 0.2 mg is given, if required repeated after 15 minutes with maximum 5 doses, 0.2 mg can be given IM every 4 hourly. • Injection PGF 2 alpha- 0.25mg IM, given if		

	required, repeated after 15 minutes with maximum of 8 doses. • Tab Misoprostol 1000 µg can be inserted per rectum. **Simultaneously:** Continuous monitoring done to check pulse, BP, SO2, and ABG. Fluid intake and urine output recorded hourly. **If Bleeding still continues.....** • Perform balloon tamponade to arrest bleeding. • Surgical intervention is done if required: Exploratory laparotomy. • Stepwise devascularization performed. • Compression sutures applied. • Ligation of anterior division of internal iliac artery done if required. • Hysterectomy is done as a last resort. **II. Uterus well contracted:** Bleeding likely due to trauma to genital tract • Exploration under sedation or preferably GA is done. • Examination of cervix and vaginal tract for tears is done. • Bimanual palpation for integrity of uterus or presence of broad ligament hematoma is done. • Surgical intervention is done if required: Exploratory Laparotomy.		
C.	**Severe Preeclampsia and Eclampsia:** • Place in semi prone position. • Call for HELP and inform consultant, senior resident anesthesia. • **Aim of management**: Maintain ABC, prevention and control of seizures, control of blood pressure and obstetrical management. **Maintain ABC:**		

	• Airway: Ensure patent airway. • Breathing: Ventilate as required. • Circulation: Evaluate pulse & BP, secure IV access safely as soon as possible with large bore cannula. If pulse or breathing is absent, initiate CPR and call anesthetist. • Urgent Investigations to be sent: Blood grouping and cross-matching , haemogram with peripheral smear for haemolysis, platelet count, coagulation screen, KFT, LFT, ECG • Monitoring: Pulse , BP, respiratory rate, temperature, SpO2 , urine for protein, hourly input- output charting. **Prevention and Treatment of Seizures:** • Drug of choice: Magnesium sulphate • Second Line drug: Phenytion • Loading dose $MgSO_4$: 4g$MgSO_4$ in 20% solution IV over 10-15 minutes and 5 gm $MgSO_4$ of 50% solution IM in each buttock • Maintenance dose $MgSO_4$: 5gm IM 4 hourly or 1 g per hour IV infusion • If seizure continues / recur: $MgSO_4$ 2g if <70 kg and 4 g if > 70kg IV as per loading dose over 5-10 mins. • If fails: Diazepam 10 ml IV or Thiopentone 50 mg IV and IPPV. • Monitor: Hourly urine output, respiratory rate & patellar reflexes – before every IM dose or every 10 minutes for first two hours and then every 30 minutes. • Stop infusion if: Urine output < 100 ml in 4 hours, Or if Patellar reflexes are absent, Or if Respiratory rate <16 breaths/minute, Or if Oxygen saturation < 90% . **Blood Pressure Control:** Drug of choice: Inj. Labetalol if blood		

	pressure is more than 160/110 mmHg. **Obstetrical Management** • There is no place for continuation of pregnancy if eclampsia ensues. • Stabilization and delivery is the key. • In eclampsia, delivery should occur within 12 hours of the onset of convulsions. • Delivery is a team effort involving obstetrician, anesthetist and pediatrician. • Termination of pregnancy to be done in all cases of eclampsia irrespective of period of gestation. • In severe preeclampsia ≥ 34- wks: termination of pregnancy is to be done. • In severe preeclampsia <34 wks: expectant management is done.		
D.	**Cord prolapse:** a) **Cord presentation**: with membranes intact, cord is seen on USG lying between the presenting part of the foetus and cervix. b) **Overt cord prolapse**: the cord passes through the cervix past the presenting part of the foetus with ruptured membranes. **Step 1:** Identify the risk factors such as multiparity, previous cord prolapse, malpresentation, polyhydramnios, multiple gestation, prematurity, low birth weight, foetal malformation, unengaged presenting part, low lying placenta, etc., may be procedure related such as ARM, external cephalic version, internal podalic version, vaginal manipulation of foetus in the presence of ruptured membranes. **Step 2:** Call the obstetrician, pediatrician and anesthetist. **Step-3:** Reduce cord compression by bladder filling: insert size 16 foley's catheter fill it with 500 ml normal saline and clamp, and position the mother in knee chest/ trendlenburg position. **Step-4:** Assess foetal well being, determine viability, confirm FHS prior to any procedure.	Senior Resident	

	If foetal heart is present, and cervix is fully dilated consider ventouse delivery without delay, And if cervix is not fully dilated LSCS should be performed. **If foetal heart is not present,** first confirm IUFD with USG and await spontaneous delivery.		
E.	**Rupture uterus:** Suspect rupture uterus when patient is in pain, shock and there is a combination of following risk factors and warning signs. **Risk Factors:** Obesity, uterine scar, oxytocies in multipara with H/O previous LSCS, grand multiparity, diagnosed CPD, malpresentation, placenta accreta, macrosomic foetus, uterine anomaly, etc. **Warning signs:** Scar pain and tenderness, persistent pain between contractions, vaginal bleeding, foetal distress, FHR deceleration. • Secure airway and give 100% oxygen 1.5 liter per minute. • Access and secure IV line with two large bore cannula. • Send blood sample for grouping cross matching and arrange at least 2 units of blood • Call seniors, anesthetist, and pediatrician. • Inform the relatives about the condition of the patient. • Take the patient for laparotomy and uterine repair/hysterectomy to be decided by the size and site of rupture, degree of bleeding and patient's fertility status. • Give prophylactic antibiotic postnatal and thromboprophylaxis as per requirement.	Senior Resident Consultant	
F.	**Sudden Unexplained Maternal Collapse:** • Call for HELP (Immediately inform consultant and call anesthetist) • **Institute basic life support** if no signs of life: (BLS guidelines) • Maintain airway, check breathing, check circulation. • **Commence CPR:** if no pulse or breathing. • If no response to CPR after 4 minutes,	Senior Resident Consultant	

	consider delivery/ perimortem caesarean section. • **Initial supportive treatment**: o Assess BP, PR, RR , SpO2. o Intubate early, may require IPPV. o Establish IV access with 2 large bore cannula. o Arrange blood & blood components as per requirement. o Catheterize. • **Investigations to be done**: Haemogram/LFT/KFT serum electrolytes, ABG, ECG , CXR USG abdomen. All these actions are to be performed concurrently with the aim to initiate basic life support and identify / treat the cause of the collapse. Evaluate history and re-examine patient to establish cause and manage accordingly. • MRP in case of retained placenta • Manage PPH as per protocol • Replacement in case of uterine inversion • Laparotomy in case of rupture uterus • Higher antibiotics to be started in case of septicemia • Anti coagulation in case of pulmonary embolism • Blood component therapy in DIC		
3. 3.3 Management of High Risk Pregnancy			
	• High risk pregnancy to be identified at the earliest, during antenatal visits or in early labour. • Management is individualized according to obstetrical and medical complications • Transferred to obstetric HDU/ICU, or in case of unavailability of any of the critical facilities required for the management of patient, such patient should be counseled and transferred to higher center as per the transfer policy of the hospital. • If there is any sign of obstetric emergency shift the patient to appropriate area in LR, (HDU/ICU where available). • Make necessary arrangements with respect to equipment, instrument and investigation. • Call the emergency team (obstetrician, anesthetist, pediatrician as per the	Doctor on duty	**Annexure-1** Identification of high risk pregnancy. **Annexure–2** High risk cases for HDU/ICU transfer Transfer /Referral protocol 2.10B

	requirement of the case)		
3.3.4 Rapid Initial Assessment			
	• On first seeing a woman who is already in labour, a rapid assessment is done to assess whether she requires urgent referral for emergency care, or is her labour progressing normally at this stage. • Check the antenatal card for booked patient, for un-booked patient take a detailed obstetric history. • Record the woman's name, age, address, gravidity and parity, last menstrual period, when she first felt the foetus, movement and how long since the first contraction. • Perform a complete head to toe physical examination. • Record vitals : PR, BP, SPO_2, temperature and FHS. • Prepare the equipment for attending labour and delivery in advance. • Inform the patient and her relatives about the condition of the patient. Take necessary consents. • Use abdominal palpation to determine the foetal presentation and position, and the extent of engagement of the presenting part. • Do vaginal examination of the woman in labour to assess cervical dilatation, foetal presentation and descent, the position of the fetal skull, and adequacy & pelvis • Ask about danger symptoms: o Vaginal bleeding, headache, convulsions, o Breathing difficulties, fever, o Severe abdominal pain , o Premature leakage of amniotic fluid. • Try to make a diagnosis, consult seniors if required and act accordingly	Doctor on duty Staff nurse	
3.3.5 Requisition of Diagnosis and Receiving of Reports			
	• Requisite laboratory investigations, blood, urine, USG, are to be prescribed in the patient's case sheet and investigation forms are to be duly filled. • Samples to be drawn, labeled properly and sent to the lab along with requisition slip.	Doctor on Duty Nursing staff Nursing Orderly Nursing staff	

	• Reports to be collected from the lab on specified time and placed in the patients file. • DOD to be informed about the receipt of reports.		
3.3.6 Intrapartum Care of Patient			
A.	**Low Risk Woman:** General physical & systemic examination is performed as under **a.First stage** • **Latent phase:** painful contraction, cervical dilatation up to 4 cm. • **Established first stage:** regular painful contractions (4-5 in 10 minutes and cervical dilatation from 4cms). • Abdominal examination is performed and documented for: lie, presentation and foetal heart rate, uterine contractions and descent of presenting part. • Per vaginal examination is performed and documented to assess: cervical dilatation & effacement and progress of labour. • Investigations: Hb%, urine, blood group, Integrated Counseling Test for rapid HIV, USG as and when desired and reports are to be collected. • Use of a partogram is recommended in active stage. • Supportive care provided**:** ambulation, nutrition, personal hygiene, and breathing / relaxation techniques. • Positions: encouraged to move and adopt whatever position they find most comfortable. • Eating and drinking: encouraged to drink during labour and may take a light diet. • Any abnormality in maternal or fetal condition during first stage: termination by caesarean section is indicated.	Nursing Staff & Doctor on Duty Nursing orderly Nursing staff Doctor on duty / Consultant	**Annexure 3 –** Checklist for functionality of Labor Room. **Annexure 4-** Seven trays in LR. **Annexure 5–** List of Equipments & Instruments **Annexure 6 –** WHO Modified partogram
	b. Second stage (Cervix fully dilated) • Reassess: Foetal heart, fetal position, station, uterine contractions and augment with oxytocin if necessary. • Monitoring: to be done for frequency of contractions and intermittent fetal heart auscultation post contractions preferably every 15 minutes/ or as under ○ B.P- - hourly	Nursing Staff Doctor on Duty	

	○ Maternal pulse - every 15 minutes. ○ FHR - every 15 minutes ○ Temperature - four hourly • Encourage active pushing during contractions, only after an urge to bear down is present. If no urge to push and normal fetal heart rate- expectant management to be done. • Distension of the perineum and presenting part visible. • Prepare for delivery- cleaning and draping of perineum. • Episiotomy only for maternal and fetal indications. Mediolateral episiotomy to be given after crowning & thinning of perineum. • Delivery is conducted using 5 Cs- clean hands, clean surface, clean blade, clean cord tie, clean cord stump. • Delayed cord clamping 1-3 minutes after delivery to prevent neonatal anemia. • The baby is placed on mother's abdomen.	Doctor on Duty Staff Nurse	
	c. Third stage of Labour **Active Management of Third stage of Labour (ATMSL)** After delivery of the baby • Uterotonics: Oxytocin 10 IU IM, Syntometrine IM (0.2 mg ergometrine & 5 IU oxytocin) or Misoprostol 600 µgm oral or sublingual. • Delayed cord clamping for upto 1-3 minutes is advisable if baby is normal. Early cord clamping (< 1 minute after birth) is recommended only if a neonate is asphyxiated and needs to be moved immediately for resuscitation. • No uterine massage till expulsion of placenta. • Watchful waiting for 1-5mins for signs of placental separation: Uterus feels hard and globular, sudden gush of blood, suprapubic bulge, permanent lengthening of cord • Delivery of placenta by controlled cord traction. Left hand: Palmar surface of fingers placed		

	above pubic symphysis and body of uterus pushed upwards & backwards. Right hand: Controlled cord traction in downward & backward direction. Continued till placenta reaches the introitus. Placenta lifted away from introitus using both hands and by rotating the placenta about the insertion site or grasping membranes with a clamp or artery. • Inspect placenta and membranes for completeness.		
	• Keep your hand on the abdomen for assessment of uterine tonus – if atonic → fundal massage. • Stitch episiotomy in layers .		
3.3.7 Immediate Postpartum Care			
	• One hour immediately after delivery is defined as the 4th stage of labour and patient is closely monitored for pulse, BP, uterine contraction and vaginal bleeding. • Postpartum complications are managed as per guidelines • Patient is monitored closely for 4 - 6 hrs in LR. • Patient is shifted to postnatal ward after she passes urine and is hemodynamically stable.	Staff Nurse Doctor on duty	
3.3.8 Essential Newborn Care			
	• Call out time of birth and sex of the baby. • Deliver the baby onto the dry pre-warmed cloth draped over the mother's abdomen. • Start drying baby within 5 seconds after birth: Wipe eyes, face, head, trunk, back, arms and legs thoroughly, check breathing while drying. • Remove wet cloth to start skin-to-skin contact. • Cover the baby with dry cloth. • Routine suctioning should not be done. **If the baby is breathing properly:** • Continue skin-to-skin contact on mother's abdomen or chest. • Do not separate the baby from the mother for at least 60 minutes, unless in respiratory distress or with maternal emergency. • Encourage breastfeeding when baby shows feeding cues.	Staff Nurse, Paediatrician or Doctor on duty Staff Nurse Staff Nurse	**Annexure 7**- Work Instructions for ENBC

	• Do eye care (before 1 hour). • Monitor the baby every 15 minutes. • Postpone bathing until after baby is 24 hours of age. • After the baby is detached from the mother's breast, weigh the baby and document. • Baby case sheet is prepared. • Identification tag is tied. • Baby is shown to the relatives. • Provide preventive measures: Vitamin K, HBV vaccine.		
3.3.9 Neonatal Resuscitation			
	If baby is gasping or not breathing: **Resuscitation** • Call for help, • Clamp/cut the cord using sterile scissors/ blade and gloves. • Transfer the baby to the newborn resuscitation area (new born corner). • Position head/neck. • Only suction if the mouth/nose are blocked or prior to bag/mask ventilation of a non-vigorous meconium stained baby • Start bag/mask ventilation with air. • (Explain the situation to the relatives of the patient.)At any time if baby starts breathing or crying and has no severe chest in-drawing, stop ventilation and observe to ensure that the baby continues to breathe well. • Check breathing and heart rate every 1 or 2 minutes of effective ventilation. • If any of the following is present: – heart rate < 100 – gasping or not breathing – severe chest in-drawing o Continue resuscitation, Take ventilation corrective steps and continue ventilation. Ensure proper seal and effective chest rise for effective ventilation. o If baby is breathing normally do routine care and record the events.	Doctor on Duty Paediatrician	**Annexure 8 --** Neonatal resuscitation
3.3.10 Admission, Shifting and Referral of Patient			
A.	• Admission of the patient is done in the LR when it is prescribed by doctor on duty. Admission can be through OPD, casualty or	Staff Nurse	

	patient can be transferred from maternity ward. • Patients get admitted through computerized admission system directly to labour room. • Sick patients are to be shifted in transport trolley or wheel chair to the LR.		
B.	**Patient transfer protocol:** • Every hospital should have their own patient transfer protocol/ SOP. • There must be reasonable ground for transfer of patient. (which must be recorded in the transfer summary). • No attended patient should be transferred without transfer summary/referral slip (for ambulatory and stable patient) • Patient's relatives to be informed and explained about the condition and reasons for transfer as soon as the decision of transfer has been made. • No hemodynamically unstable patient should be transferred; every effort should be made to stabilize the patient before transferring. • If it is not possible to stabilize the patient, transfer in an adequately equipped ambulance and available trained staff. • It must be for the benefit of the patient. • A permission of consultant of the concerned department is must before transferring the patient. (written/ telephonic permission is taken, which should be recorded and is to be confirmed by the consultant on next working day). • There should be a hospital policy for transferring the patient, with respect to ambulance / doctor and paramedic to accompany the patient. • A record of all transfers to be maintained at department level.(patient out-transfer register) • Transfer summary must contain: o History, clinical examination, investigation reports if any, ECG, X-Ray, USG reports, treatment provided. o Reasons for transfer. o What exactly is required which is not available in the transferring hospital. o Whether a formal call to the referral		

	hospital was made, if yes it should also be recorded in the summary. ○ If for any reason it was not possible to contact the referral hospital reasons for the same should also be recorded. ○ Transfer summary must contain legible name and designation of the transferring doctor. • For EWS patient transfer, the guidelines issued by DHS to be followed. • In case a low risk / manageable patient or their relative wants a transfer, against the advice of doctor it should be recorded in the case sheet and on the discharge summary along with the signatures of the patient / her relatives.		
3.3.11 Arrangement for Interventions in Labour Room			
A.	**Induction of Labour:** • It should be a decision of senior resident or consultant. • There should be a valid indication for induction. • Patient is counselled about the need of induction, method of induction and need for caesarean section in case of emergency or failure of induction. • Informed written consent is taken. • If CTG machine is available, NST is done, should be reactive. • Bishop score is assessed. If Bishop score is unfavourable (<6): cervical ripening is done by PGE2 intracervical gel or mechanical means e.g. foley's catheter or dilapan S, followed by oxytocin & ARM. • Bishop score favourable (>6): induction with oxytocin and ARM is done. • Monitoring for maternal pulse, uterine contractions and foetal heart is done. • Labour monitoring is done as per partogram.	Senior Resident Consultant,	
B.	**Instrumental delivery- Forceps or Ventouse:** • Instrumental delivery is to be performed by senior resident or consultant. • Case is reviewed. Complete abdominal and vaginal examination is performed to determine the valid indication for	Senior Resident, Consultant	

	instrumental delivery, whether prerequisites are met and classified i.e. outlet or low-mid cavity. • Informed consent is taken from the patient. Verbal consent is acceptable in labor ward, but written consent should be obtained in cases of trial of instrumental delivery in operation theatre. • Ensure presence of pediatrician trained in neonatal resuscitation during the delivery. • Appropriate technique in conducting the delivery with the chosen instrument is applied. Optimal uterine contractions ensured and fetal heart rate is closely monitoring during the procedure.		
C.	**Emergency Caesarean Section:** • Decision for caesarean section shall be taken by doctor on duty and confirmed by senior doctor (on call in emergency hours). • IN CASE OF immediate threat to the life of the woman or fetus decision-to-delivery interval should be not more than 30 minutes **Category 1-** e.g. cord prolapse, fetal distress, APH with active bleeding etc. **Category 2 -** Maternal or fetal compromise which is not immediately life-threatening (decision-to-delivery intervals 30 and 75 minutes e.g. cervical dystocia. **Category 3** - No maternal or fetal compromise but needs early delivery e.g. breech in early labour. • Pregnant women with antepartum haemorrhage, abruption, and placenta praevia should have the cesarean section carried out at a hospital with on site blood transfusion services. • Informed written consent is taken • Investigations: Haemoglobin, grouping cross-matching of blood, clotting screen (optional) & preoperative ultrasound for	Senior Resident, Consultant	

	localization of the placenta is (not needed in low risk patients) done. • The team is notified (including for indication of cesarean section): sister incharge OT, operating assistant, anesthetist, and pediatrician. • Antacids and drugs (eg. Inj. Ranitidine 50mg IV) to reduce aspiration pneumonitis, antiemetics (eg. Inj. Perinorm 10mg IM) to reduce nausea and vomiting given. • Timing of antibiotic administration – Administer prophylactic antibiotics (1st generation cephalosporin) at cesarean before skin incision. Choose antibiotics effective against endometritis, urinary tract and wound infections. Do not use co-amoxiclav when giving antibiotics before skin incision.		
3.3.12	**Transfusion of blood**		
A.	**Perquisites for blood transfusion:** • A doctor's order on the patient case sheet is must for transfusion. • Quantity of blood/component and rate of transfusion must also be prescribed in the case sheet.	Doctor on Duty	
B.	**Informed consent for blood transfusion:** • The patient is informed about the medical indications for the transfusion, the possible risks, the possible benefits, the alternatives, and the possible consequences of not receiving the transfusion. • Consent is obtained sufficiently in advance of the transfusion so that the patient can truly understand what is said and has sufficient time to make a choice, whenever feasible. • Consent is documented duly signed by patient/ relative/ doctor/nurse • A single informed consent may cover many transfusions if they are part of a single course of treatment. • It may be advisable, though, to **obtain a new consent when there is a significant change** in the patient's care status, such as a transfer for care to another service, an		

	inpatient admission, or an outpatient transfusion. • In **emergency situations** the physician ordering the transfusion must make a reasonable judgment that the patient would accept the transfusion. Transfusion should not be delayed in a life-threatening situation if it is likely that the patient would agree to transfusion. After the event, the circumstances of the transfusion decision should be documented in the case sheet of the patient.		
C.	**Requisition of blood component:** • Blood sample of the patient is sent to the blood bank for grouping and cross matching, along with blood requisition form (should clearly mention name of the required product and number of units required). • Availability of requisite product is ascertained from blood bank. • If blood is required at a later time, blood bank is informed and asked to keep the cross matched blood reserved for the patient till such time. • If it is urgent and life saving, it is clearly mentioned in the requisition form. • A blood release form is sent to the blood bank, one bag at a time if no storage facility is available in house, If there is a facility for storage (Blood bank refrigerator is available) the total quantity is required to be released from the blood bank.		**Annexure 1 of SOP Maternity Ward -** Check list for Requisition form
D.	**Receive the blood and verify that:** • Blood is designated for a patient for whom requisition was sent. • Release form bears all the details along with the signature of blood bank staff. • Name and CR number recorded on the release form attached to the unit corresponds with that of the intended patient. • Check, ABO Rh type, patient name/ CR No./ blood bag no and date of expiry of the blood component. • Unit has a normal appearance and is cold. • **In case of any discrepancy inform the**		**Annexure 2 of SOP Maternity Ward -** Checklist- Before starting blood transfusion

	blood bank immediately, do not transfuse till everything has been clarified from the blood bank. • Record the date and time of receipt of blood bag in the ward on the blood bank release form. • Check the patient case sheet for transfusion order, type, volume and rate of transfusion. • Check if any pre medication is prescribed. Medicate the patient accordingly. • Verify the patient's name / CR No. blood bag for component type/ group/ expiry date. • Check, and record the patient's blood pressure, pulse, respiration and temperature in the chart or on the case sheet with date and time of starting transfusion. • Immediately before transfusion, mix the unit of blood thoroughly by gentle inversion. • If rapid and large volume transfusion is required a blood warmer can be used if available.		
E.	**Start transfusion if everything is in order:** • Initial flow rate should be slow not more than 1 ml/minute to allow for recognition of an acute adverse reaction. Proportionately smaller volume for pediatric patients. • If no reaction occurs for first 15 minutes increase the rate to 4 ml / min; usual transfusion time is 2-4 hours, and it should not exceed 4 hours for any component. • Platelets, plasma and cryoprecipitate: 10 ml per minute. The transfusion may be administered as rapidly as the patient can tolerate, usually 30 minutes. • During transfusion monitor the vitals of the patient every 30 minutes (PR, BP, RR, SpO2, temp and any sign of urticaria) • Assess the flow rate, if unusually slow (less than 3 ml/min.) consider the following to enhance the flow rate.		

	▪ Repositioning the patient's arm. ▪ Changing to a larger gauge needle. ▪ Changing the filter and tubing. ▪ Elevating the IV pole. ▪ Consider using a transfusion pump if available.		
F.	**Signs of blood transfusion reaction:** • Hives and itching**:** Are non serious reactions generally controlled by antihistaminic/ steroid and slowing the rate of infusion. • Isolated fever**:** Developing a fever after a transfusion is not serious. Fever is body's response to the white blood cells in the transfused blood. (slow the rate of infusion.) • However, it can be a sign of a serious reaction if the patient is also experiencing nausea, vomiting, back or chest pain, dark colored urine. STOP TRANSFUSION IMMEDIATELY AND INFORM THE BLOOD BANK AND TREATING DOCTOR. **If a transfusion reaction is suspected** • Stop the transfusion. • Maintain IV with normal saline. • Save the bag and attached tubing, send it to the blood bank for investigation.		**Annexure 3 of SOP Maternity Ward** - Checklist in case of a blood transfusion reaction
G.	**In case of uncomplicated transfusion.** • Record date and time when transfusion was stopped. • Record volume of blood infused. • Document the presence/absence of a transfusion reaction in the patient case sheet. • Discard the blood bag and tubing as per BMW guidelines. • Outpatients or patients who will be leaving the hospital within one week of transfusion should be given written instructions regarding delayed transfusion reactions and asked to report immediately.		
3.3.13 Distinguishing Between Newborn Death and Still Birth			
	• **New born death** or neonatal death is defined as death of a newborn who has shown some signs of life immediately after birth. It is called as ea**rly neonatal death** if the baby dies within	Obstetrician Pediatrician Staff Nurse	

	7 days of birth, and up to 28 days it is called l**ate neonatal death.** • A new born is declared as **Still born** when there are no signs of life on delivery. • Filling of forms : Still birth from by obstetrician. Neonatal death form by pediatrician. • Body is handed over to go the relatives.		
3.3.14 Environmental Cleaning and Processing of the Equipment in LR			
	• Traffic in labor room is kept minimal**.** • Only staff that is required for procedures is allowed in labor room. • External foot wears are not allowed in the area. • All health care providers involved in direct care of patients MUST use personal protective equipment. • After every procedure all working surfaces are disinfected.		
	Following practices to be followed in LR by all staff: • Hand washing and antisepsis (hand hygiene). • Use of personal protective equipment when handling blood, body substances, excretions and secretions. • Appropriate handling of patient care equipment and soiled linen. • Prevention of needle stick/sharp injuries. • Environmental cleaning (cleaning of surfaces) and spills-management. • Appropriate handling of waste (as per biomedical waste management handling guidelines).		
A.	**Wash or decontaminate hands:** • After handling any blood, body fluids, secretions, excretions and contaminated items. • Between contact with different patients. • Between tasks and procedures on the same patient to prevent cross contamination between different body sites. • Immediately after removing gloves. **Antimicrobial soap:** Used for hand washing as well as hand antisepsis. • If bar soaps are used, use small bars and soap		**Annexure-9** Pictorial chart for steps of hand washing

	racks which drain. • Do not allow soap bar to sit in a pool of water as it encourages the growth of micro-organisms such as pseudomonas. • Clean dispensers of liquid soap thoroughly every day. • When liquid soap containers are empty they must be discarded, not refilled with soap solution. **Specific antiseptics recommended for hand antisepsis:** • 2%-4% chlorhexidine. • 5%-7.5% povidone iodine. • 1% triclosan. • 70% alcoholic hand rubs. • Waterless, alcohol-based hand rubs: with antiseptic and emollient gel and alcohol swabs, which can be applied to clean hands. • Dispensers for hand rub should be placed near all tables in LR.		
B.	**Use of personal protective equipment:** • Health care workers who provide direct care to patients and who work in situations where they may have contact with blood, body fluids, excretions or secretions. • Support staff including medical aides, cleaners, and laundry staff in situations where they may have contact with blood, body fluids, secretions and excretions. • Personal protective equipment includes: o Gloves o Protective eye wear (goggles) o Mask o Apron o Gown o Boots/shoe covers o Cap/hair cover • After use discard the personal protective equipment in appropriate disposal bags, and dispose of as per the BMW policy of the hospital. • Do not share personal protective equipment. • Change personal protective equipment completely and thoroughly wash hands each time you leave a patient to attend to another patient or another duty.		

C.	**Appropriate handling of patient care, equipment handling and soiled linen:** • Handle patient care equipment soiled with blood, body fluids secretions or excretions with care in order to prevent exposure to skin and mucous membranes, clothing and the environment. • Ensure all reusable equipment is cleaned and reprocessed and sterilized appropriately before being used on another patient. • Mattresses with plastic covers should be wiped with a neutral detergent. • Mattresses without plastic covers should be steam cleaned if they have been contaminated with body fluids. • If this is not possible to decontaminate the bedding it should be removed by manual washing, ensuring adequate personnel and environmental protection. **Linen handling:** • Place used linen in appropriate bags at the point of generation. • Contain linen soiled with body substances or other fluids within suitable impermeable bags and close the bags securely for transportation to avoid any spills or drips of blood, body fluids, secretions or excretions. Bags to be stored and transported in a leak proof container. • Do not rinse or sort linen in patient care areas (sort in appropriate areas). • Handle all linen with minimum agitation to avoid aerosolization of pathogenic micro-organisms. • Separate clean from soiled linen and transport/store them separately. • Transport and process used linen, and linen that is soiled with blood, body fluids, secretions or excretions in separate leak proof bags with care to ensure that there is no leaking of fluid.	Staff Nurse, Nursing Orderly, Housekeeping staff.	
D.	**Prevention of needle stick/sharps injuries:** • Take care to prevent injuries when using needles, scalpels and other sharp instruments		

	or equipment. • Place used disposable syringes and needles, scalpel blades and other sharp items in a puncture-resistant container with a lid that closes and is located close to the area in which the item is used. • Take extra care when cleaning sharp reusable instruments or equipment. • Never recap or bend needles. • Sharps must be appropriately disinfected and/or destroyed as per the national standards or BMW guidelines.		
E.	**Environmental cleaning(cleaning of surfaces) and spills-management:** • Labour room along with all equipments and all surfaces should be cleaned every morning. • All toilets to be cleaned using surface disinfectant at the start of every shift. • The floor and sink should be cleaned with detergent soap at the start of every shift. • Mopping of floors (at the start of every shift/ and SOS for spillage). Procedure for mopping described as under. o Clean water is taken in three bucket numbered 1, 2 and 3. o Surface disinfectant is added in bucket no.3 (so that 1st and 2nd bucket has clean water and third bucket has disinfectant). o Cleaning of floor begins from inside to outside. Towards the end all corner and groves to be cleaned. o After each sweep of the floor the mop should be dipped first in bucket no. 1, then in no.2 and lastly in no.3 and then floor is mopped again. This process is repeated till the whole area is cleaned. o Water of the three containers to be changed (depending on the size of the ward) as the water in 3rd bucket gets dirty. o Mops to be cleaned in dirty utility area and put in a stand under sun with head of the mop upward, and mops should not be left wet in the ward or any patient area. o After mopping blood or body fluids the mop should be treated as soiled linen and discarded as per BMW guidelines. o Mops should be visibly clean before starting cleaning of a ward	Staff Nurse/ Housekeeping staff	

	• Handle patient care equipment soiled with blood, body fluids secretions or excretions with care in order to prevent exposure to skin and mucous membranes, clothing and the environment. • Ensure all reusable equipment is cleaned and reprocessed and sterilized appropriately before being used on another patient. • Universal safety guidelines to be followed by all staff members working in the ward.		
F.	**Handling of general and biomedical waste in LR:** To be done as per the biomedical waste management and handling guidelines.		
3.3.15 Maintenance of Rights and Dignity of the Patient			
	• Maintenance of women's rights, dignity, privacy and confidentiality is responsibility of every doctor and staff involved in the care of the patient. • Patient's right and responsibilities should be displayed in local language in all patient waiting areas and wards. • Social workers and nurses should also educate the patients about their right and responsibilities. • All Doctors and paramedical staff should be made aware of the right and responsibilities of the patients.		
A.	**Patients rights:** a) Care: • Patients have a right to receive treatment irrespective of their demographic profile. • Right to be heard regarding her concerns. b) Confidentiality and Dignity: • Right to personal dignity and to receive care without any form of stigma and discrimination. • Privacy during examination and treatment. • Protection from physical abuse and neglect. • Accommodating and respecting their special needs such as spiritual and cultural preferences. • Right to confidentiality about their medical condition. c) Information: The information to be provided to		

	patients is meant to be in a language of patient's preference and in a manner that is effortless to understand. • Patients and/ or their family members have the right to receive complete information on the medical problem, prescription, treatment & procedure details. • A documented procedure for obtaining patient's and / or their family's informed consent exists to enable them to make an informed decision about their care. • Patients have to be educated on risks, benefits, expected treatment outcomes and possible complications to enable them to make informed decisions, and involve them in the care planning and delivery process. • Patients or their authorized individuals have the right of access and to get a copy of their clinical records on their written request. d) Preferences: • Patients have a right to seek a second opinion on their medical condition. • Right to information from the doctor to provide the patient with treatment options, so that the patient can select what works best for her.		
B.	**Patients responsibility**: a) Honesty in disclosure: • Patients shall be honest with doctor & disclose their complete family/ medical history whenever asked. b) Treatment compliance: • Patients shall do their best to comply with doctor's treatment plan. • Patients shall have realistic expectations from the doctor and his/her treatment. • Inform and bring to the doctor's notice if it has been difficult to understand any part of the treatment or of the existences of challenges in complying with the treatment. c) Transparency and honesty: • Patients shall make a sincere effort to understand their therapies which include the medicines prescribed and their		

	associated adverse effects and other compliances for effective treatment outcomes. • If not happy, patient shall inform and discuss with her doctor/ administration. • Patients shall report any fraud and wrong doing by any staff member or person in the hospital. d) Conduct: • Patients shall be respecting the doctors and medical staff. • Patients shall abide by the hospital / facility rules.		
3.3.16 Record Maintenance including Taking Consent			
A	**Record maintenance in Labour Room:** • A record index should be available in every ward and it should contain: o List of all forms o List of all registers • Management of patient's case sheet: o A separate file is created for every patient admitted or transferred to LR o The cover of the file must contain CR No. / Name, Husbands Name/Age / Sex/ of the patient. o Following forms and documents are to be kept in patient's file in chronological order. o ANC card when available, clinical notes, treatment sheets, progress notes. o Investigation reports o LR notes. o Blood Transfusion notes. o Interdepartmental consultation/ referral records. o Baby admission slip. o Baby clinical notes and treatment notes. o Birth form. o Discharge /transfer/ death summary of the patient. • The completed records (case sheet of the patient is transferred to MRD after discharge, death and transfer of the patient along with birth/ death form duly completed). • While transferring the records to MRD nursing staff must verify the record is complete in every respect and documents are duly signed		

	by respective doctors. • Management of ward registers: o All important registers such as admission register, birth/ death register, daily census register etc. are to be transferred to MRD after their completion. o Rest of registers such as treatment book, injection register, lab register etc to be retained and weeded as per the record retention schedule of the hospital.		
B.	**Taking informed consent of patient:** • Informed consent to be taken apart from general form of authorization for medical and surgical management. • Is taken for all surgical procedures, blood transfusion, invasive procedures, etc. • Before any of the above procedure patient and their relatives are informed about the planned procedure in a language they can understand easily. • Preferably in presence of a staff nurse. • They are explained in detail about the procedure, its benefits, risk and available alternatives. • Also explained the risks and complications that may arise on refusing the planned procedure. • All queries of patient and their relatives are to be answered to their need and satisfaction. • After the counseling is complete and patient /and or their relative agree, the informed consent is prepared, read aloud to the patient and signed by the patient and witnesses.	Doctor on Duty Staff Nurse	

ANNEXURES

Annexure 1. HIGH RISK CASES

IDENTIFICATION OF HIGH RISK PREGNACY

(To be referred to secondary/ tertiary care centre as per facilities available in the health unit)

Personal/Past health factors	**Ongoing maternal and/or fetal problems**
Age < 18 years or > 35 yrs	Post dated
Short statured height <140 cm	Preterm labor/Premature rupture of membranes/ PPROM
H/O consanguinity	Maternal weight > 90 kg excessive obesity or < 45 kg
Smoking, Alcoholism, Substance/ Drug	IUGR/ Uteroplacental insufficiency

Abuse	
Parity ≥ 5	Cephalopelvic disproportion/Obstructed labor
Treatment for infertility and use of ovulatory drugs	Vaginal bleeding in early pregnancy, Molar pregnancy, Ectopic pregnancy
Chronic medical disorders	Third trimester vaginal bleeding-Placenta Previa, Abruptio
Previous uterine surgery -cesarean section myomectomy. cervical cerclage	Oligoamnios,Hydramnios
Bad Obstetric History	Malpresentation
Previous Rh isoimmunization/ hydrops fetalis	Uncontrolled Hyperemesis gravidarum
	Multiple Pregnancy,
	Severe Anemia Hb <= 7 gm%
	Gestational Hypertension
	Gestational Diabetes
	Jaundice
	HIV Positive/AIDS, Hepatitis B Positive

Annexure 2.HIGH RISK CASES REQUIRING ADMISSION IN HDU/ICU

(To be referred to tertiary care centre)
obstetric ComplicationsObstetric Complications Pregn

OBSTETRIC COMPLICATIONS	PREGNANCY WITH MEDICAL DISORDERS
Accidental Hemorrhage- Placental Abruption, Couvelaire Uterus	Pregnancy/Labor Pain with Severe Anemia (< 7 gm %) and its complications
PostPartum Hemorrhage	Pregnancy with Gestational Diabetes
Placenta Previa	Pregnancy with Diabetic Ketoacidosis
Adherent Placenta and other placental abnormalities	Pregnancy with Cardiac Diseases
HELLP Syndrome	Pregnancy with Jaundice
Severe Pre-eclampsia/Hypertensive Crisis	Pregnancy with Thyrotoxicosis,Thyroid Storm
Eclampsia	Pregnancy with DIC
Multiple Gestation with complications	Pregnancy with Pheochromocytoma
Pregnancy with complications due to Uterine Anomaly and Pathologies	Pregnancy with Bleeding Disorders
Ruptured Ectopic	Pregnancy with Dengue, Complicated Malaria
Hydatidiform Mole	
Sepsis & Systemic Inflammatory Response Syndrome (SIRS)	
Obstetric Hysterectomy	
Postoperative patients requiring hemodynamic monitoring or intensive nursing care	

Modified from : Guidelines on Obstetric HDU and ICU, March 2016, Department of Health and Family Welfare, Govt. of India.

Annexure 3.CHECKLIST LR FUNCTIONALITY

Source: Department of H&FW, GOI

Labor Room Functionality Checklist

Facility Name: **Date:**

1. **Infrastructure :** yes/ No

24*7 Water	24*7/ Electricity	24*7Telephone	24*7Refrigerator	Number of labour table	Number of stepping stool	Screens available between the Labor tables	Availability of Mattresses & Kelly pads on labor tables	Wheel chair	Trolleys	Elbow Tap in Wash Area

2. **Equipment's and Logistics:** yes/ No

Functional BP apparatus	Stethoscope (Adult & Pediatric)	Fetal Doppler	Functional CTG Machine	Functional Suction Machine	Adult weighing machine	Oxygen Supply

3. **Functional NBCC (Including all NBCC componeents):** yes/ No

Baby Weighing scale (digital)	Functional Radiant warmer	Room temperature thermometer	Functional Bag & Mask 0 & 1 size	Oxygen Hood	Shoulder Roll	Dee Lees mucus extractor	Two pre warmed sheets	Low temp thermometer	Laryngoscope with charged cells	Foot operated Suction machine

4. **Essential Drugs Status:** yes/ No

Inj. Oxytocin	Inj. Magsulf	Inj. Labetalol	Tab Labatelol	Cap Nifedipine	Tab Misoprostol	Inj Carboprost	Dynaprostone gel	Inj Vit K 1

5. **Essential Trays availability:** yes/ No

Delivery tray	Eclampsia tray	Emergency tray	PPIUCD tray	Medicine tray	Baby tray	MTP tray

6. **24*7 Lab Facility :** yes/ No

Hb	Urine for Albumin & Sugar	LFT	KFT	HIV	VDRL	HBsAg	Blood Sugar	blood coagulation profile	Blood Group & cross matching

7. **X ray / ECG / USG 24x 7 availability / Blood Bank/ BSU :** Yes/ No

8. **Biomedical Waste Practices:** Protocol posters / Elbow tap/ universal precaution (HIV & HBsAg) /labour room sterilization register/disposable shoe & head caps/Colored Waste Bins

Plan of Action suggested (with Time–Line for Gap rectification): ----------

Sister in charge
Signature / Name

In-charge of Labor Room
Signature / Name

Copy to HOD / MS/ DFW

Directorate of Family Welfare

Annexure 4 : .CONTENTS OF 7 TRAYS IN LABOUR ROOM

Source: Modified from "Guidelines for Standardization of Labor Rooms at Delivery Points", Ministry of H&FW, Govt. of India, March 2016.

Tray 1: Delivery Tray

SNo.	Content	SNo.	Content
1.	Gloves	2.	Scissors
3.	Artery forceps	4.	Cord clamp
5.	Sponge holding forceps	6.	Urinary catheter & Urobag
7.	Bowl for antiseptic lotion	8.	Gauze pieces
9.	Cotton swabs	10.	Speculum
11.	Sanitary pads	12.	Kidney tray
13.	Sterilized linen	14.	Kelley's pad

Tray 2: Episiotomy Tray

SNo.	Content	SNo.	Content
1.	2% Inj. Xylocaine	2.	10 ml disposable syringe and needle
3.	Episiotomy scissors	4.	Kidney tray
5.	Artery forceps	6.	Allis forceps
7.	Sponge holding forceps	8.	Toothed forceps
9.	Needle holder	10.	Thumb forceps
11.	Sim's speculum	12.	No. 0 Chromic catgut/ Polygalactin rapid no 0 or 2 0
13.	Gauze pieces	14.	Cotton swabs
15.	Gloves	16.	Antiseptic lotion
17.	Sterilized linen/gynae sheet		

Tray 3: Baby tray

SNo.	Content	SNo.	Content
1.	Pre-warmed towel/sheets	2.	Cotton swabs
3.	Mucus extractor	4.	Bag and mask
5.	Sterilized thread for cord or cord clamp	6.	Nasogastric tube
7.	Gloves	8.	In. Vit. K
9.	Needle and syringe		

Tray 4: Medicine tray

SNo.	Content	SNo.	Content
1.	Inj. Oxytocin 10 IU	2.	T. Misoprostol 200 mcg
3.	Inj. PG F2 alpha	4.	Inj. Methylergometrine
5.	Cap. Ampicillin 500 mg	6.	T. Metronidazole 400 mg
7.	T. Ibuprofen	8.	T. B-complex
9.	T. Paracetamol	10.	Inj. Gentamycin
11.	Inj Dexamethasone	12.	Inj. Betamethasone
13.	Ringer lactate	14.	Normal saline
15.	Inj. Hydralazine	16.	Inj Labetolol
17.	T. Methyldopa	18.	Cap. Nifedipine
19.	Inj. Vit K	20.	Magnifying glass

Tray 5: Emergency tray for Labor Room and Maternity Ward

SNo.	Content	SNo.	Content
1.	Inj. Adrenaline	2.	Inj. Diazepam
3.	Inj. Calcium gluconate 10%	4.	Inj. Atropine
5.	Inj. Soda bicarbonate	6.	Inj. Hydrocortisone Succinate
7.	Inj. Pheniramine maleate	8.	Inj. Lignocaine 2%
9.	Inj. Magsulf 50%	10.	Inj. PG F2 alpha
11.	Inj. Labetolol/Inj . Hydralazine	12.	Ringer lactate
13.	Normal Saline	14.	IV sets with two 16-guage needles
15.	IV Cannula	16.	Vials for drug collection
17.	Controlled suction catheter	18.	Mouth gag
19.	Foleys catheter	20.	Urobag
21.	Endotracheal tube	22.	Ambu Bag and Mask
23.	Laryngoscope	24.	Defirillator AED device

Tray 6: Evacuation / D&E tray

SNo.	Content	SNo.	Content
1.	Gloves	2.	Anterior vaginal wall retractor
3.	Sim's Speculum	4.	Sponge holding forceps
5.	Suction Cannula different sizes	6.	Stainless steel bowl
7.	Antiseptic lotion	8.	Endometerial curette
9.	Hegar's cervical dilator set	10.	Sanitary pads
11.	Cotton swabs or pads	12.	Disposable syringe and needle
13.	Sterilised gauze/pads	14.	Urobag
15.	Foley's catheter	16.	T . Misoprostol
17.	Inj. Oxytocin	18.	In. Methylergometrine
19.	Sterilized linen	20.	

Tray 7: PPIUCD TRAY

SNo.	Content	SNo.	Content
1.	PPIUCD insertion forceps	2.	Cu IUCD 380A or 375
3.	Sim's speculum	4.	Sponge holding forceps
5.	Stainless steel bowl	6.	Sterilized linen
7.	Antiseptic solution	8.	Gloves

Annexure 5.THE FACILITY HAS EQUIPMENT & INSTRUMENTS REQUIRED FOR ASSURED LIST OF SERVICES.

S. No.	ITEM
1.	BP apparatus, stethoscope ,thermometer, foetosope/ docppler, baby weighting scale, wall clock (tracers).
2.	Scissor, rtery forceps, cord clamp, sponge holder, speculum, kocker's forceps, kidney tray,bowl for antiseptic lotion.
3.	Episiotomy scissor, kidney tray, artery forceps, allis forceps, sponge holder, toothed forceps, needle holder ,thumb forceps.
4.	Two pre warmed towels/sheets for wrapping the baby, mucus extractor, bag and mask (0 &1 no.), sterilized thread for cord/ cord clamp, nasogastric tube.
5.	Speculum, anterior vaginal wall retractor, posterior wall retractor, sponge holding forceps, MTP cannulas, small bowl of antiseptic lotion.
6.	PPIUCD insertion forceps, Cu IUCD 380A/ Cu IUCD375 in sterile package.
7.	Glucometer, Hand held fetal Doppler and HIV rapid diagnostic kit.
8.	Oxygen, Suction machine/ mucus sucker ,radiant warmer, Laryngoscope adult and neonatal.
9.	Suction machine, oxygen, Adult and neonatal bag and mask, mouth gag.
10.	Refrigerator, crash cart/ drug trolley, instrument trolley, dressing trolley,light source.
11.	Buckets for mopping, separate mops for labour room and circulation area duster, waste trolley, deck brush.
12.	Boiler/Autoclave.
13.	Hospital grade mattress, IV stand, Kelly's pad, Support for delivery tables, macintosh, foot step, bed pan.
14.	Wall clock with second arm, lamps- wall mounted /side, electrical fixture for equipments like radiant warmer, suction.

Source: Assessors Guidebook for QA, GOI

Annexure 6 :MODIFIED WHO PARTOGRAM

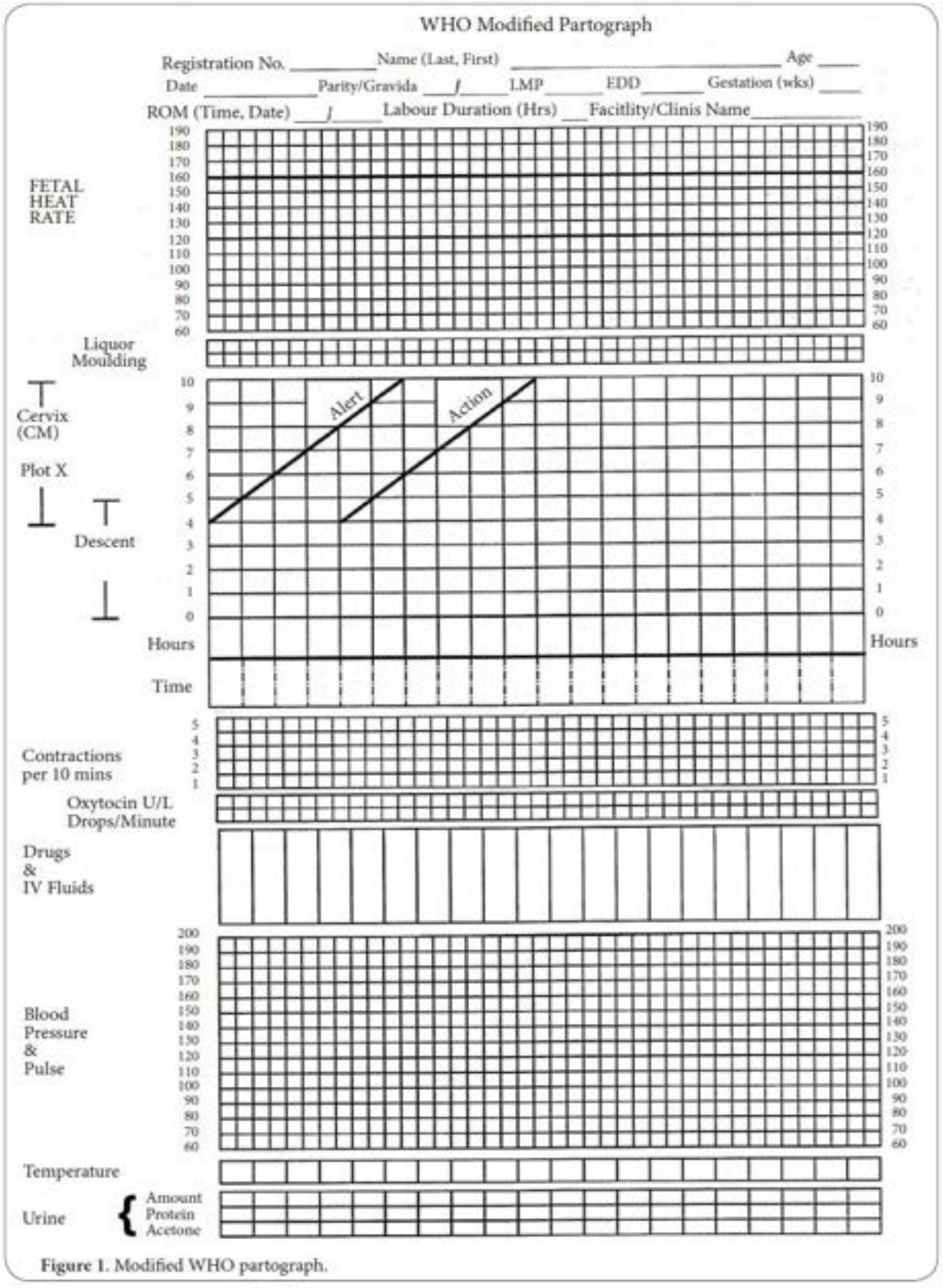
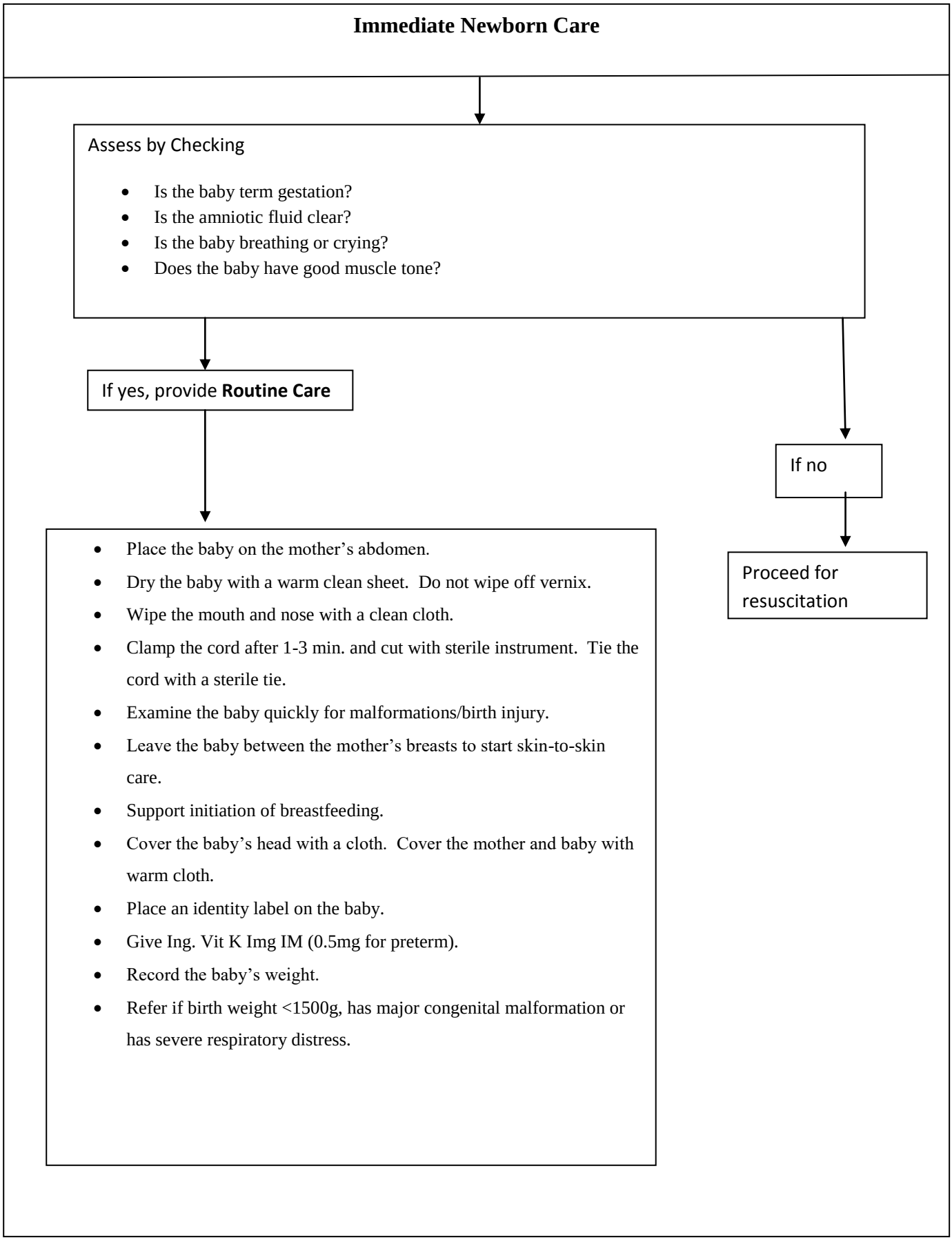
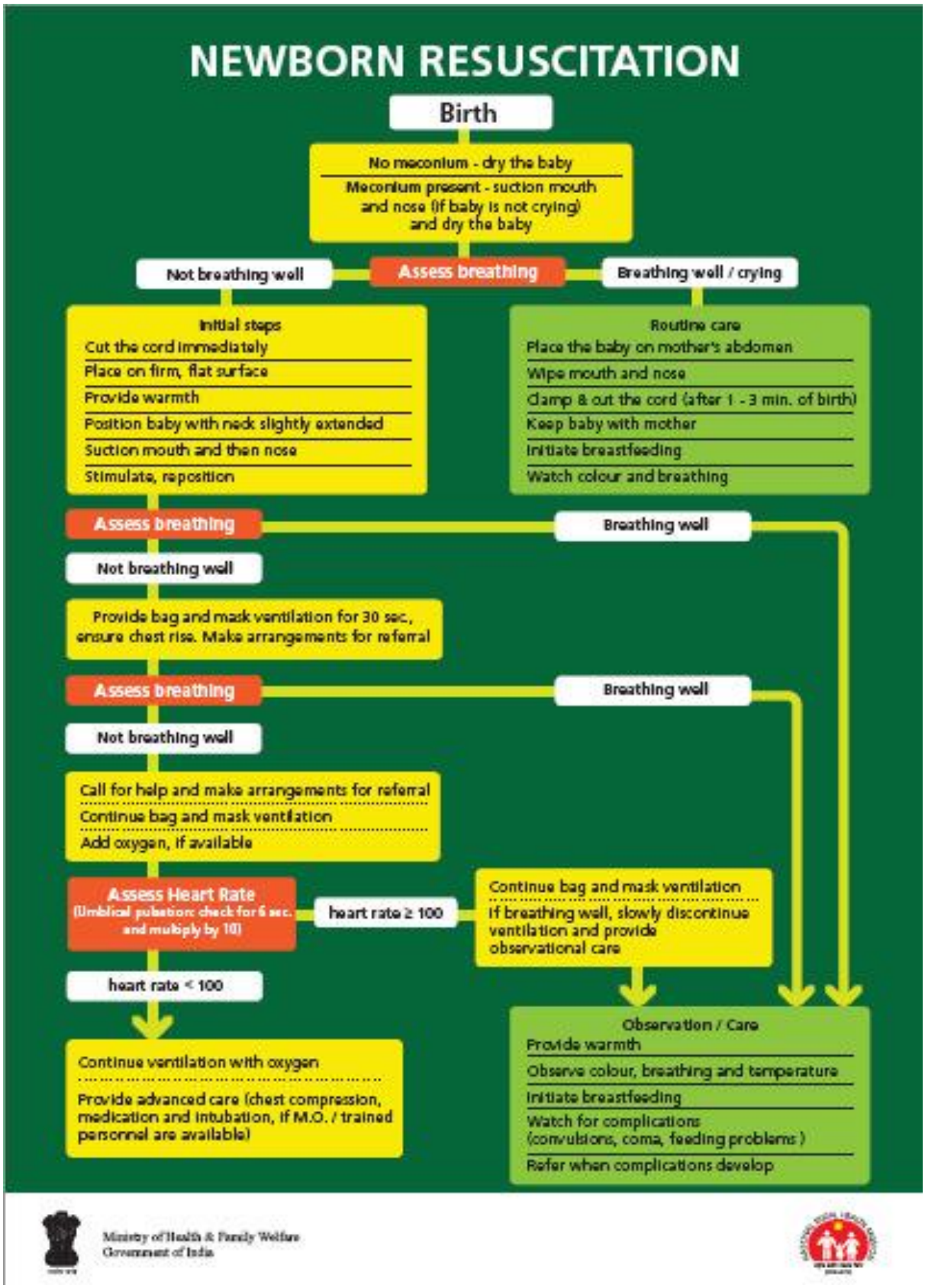


Figure 1. Modified WHO partograph.

Annexure 7 WORK INSTRUCTIONS –ENBC (ESSENTIAL NEW BORN CARE)



Annexure8.NEONATALRESUSCITATION

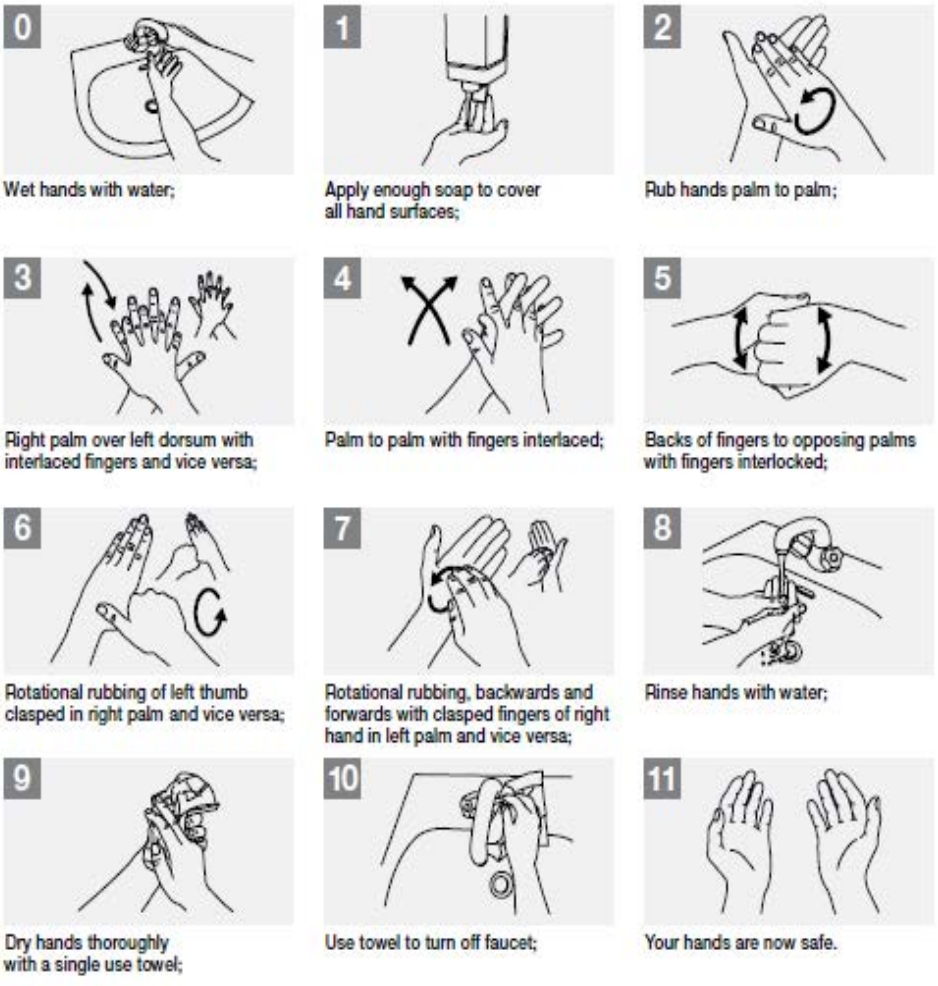


Annexure 9.PICTORIAL HAND WASHING INSTRUCTIONS

HOW TO HANDWASH?

WASH HANDS WHEN VISIBLY SOILED! OTHERWISE, USE HANDRUB

Duration of the entire procedure: 40-60 seconds



Hand care

- Take care of your hands by regularly using a protective hand cream or lotion, at least daily.
- Do not routinely wash hands with soap and water immediately before or after using an alcohol-based handrub.
- Do not use hot water to rinse your hands.
- After handrubbing or handwashing, let your hands dry completely before putting on gloves.

Please remember

- Do not wear artificial fingernails or extenders when in direct contact with patients.
- Keep natural nails short.

4. MATERNITY WARD

4.1 Purpose:

Purpose of this SOP is to ensure that all antenatal & postnatal patient are provided with evidence based quality care in an environment of minimal risk covering every aspect of obstetric care from the time patient is received in antenatal / postnatal ward.

4.2 Scope:

This SOP covers all the processes and guidelines to be followed by all doctors, nurse, paramedical & other support staff involved in the management of the patient in maternity ward with an objective of good maternal & foetal outcome. Providing care during antenatal/postnatal period including transfer/referral/discharge.

4.3 Responsibility:

Responsibility is divided among the doctors and staff posted in maternity ward.

4.4 Procedure:

Sr. No.	Activity	Responsibility	Reference
4.4.1 Receiving and assessment of the patient in maternity ward.			
A.	**Receiving of the patient:** Patient is received in ward after admission of the patient through OPD / ANC clinic or emergency.	Nursing Staff	
B.	Documentation of personal details of the patient in ward admission registers. Complete workup for unbooked patient is to be done immediately after admission	Nursing Staff	
C.	**Initial assessment:** • ANC card, all investigation reports of the booked patient is asked for. • A quick assessment of the patient is done by the doctor on duty in a designated room with complete privacy. • Provisional diagnosis is made depending on the findings of history examination and investigations. • Patient is categorized as low risk and high risk.	Doctor on duty	
D.	**Low risk patient:** Are provided bed with clean linen, diet, medication, investigations as per diagnosis or plan of treatment. Patient is shifted to labour room if she goes in labour. Trolley/wheelchair to be provided in the ward.	Nursing Staff/Doctor on duty	

E.	**High risk patient:** Depending on the facilities available in hospital patient is either. A. Shifted to HDU/ICU/ward after counseling and documentation of prognosis. For ANC patient having medical/surgical disorder inter-departmental referrals to be taken to provide comprehensive care. B. In case of unavailability of any of the critical facilities required for the management patient is counseled and transferred to higher centre as per transfer policy of the hospital.	Doctor on duty	Refer Annexure-2 of OPD: FORM -F
F.	**Diagnosis** is made of pregnancy with any associated existing condition. Report sent from the ward to be collected by the staff and attached in the file of the concerned patient.	Doctor on duty /Nursing Staff	
G.	**Daily monitoring** of patient is performed regarding vitals, (Pulse, BP, Temperature, Respiration, Input/ Output charting) control of medical disorder and foetal growth monitoring (fundal height and growth, FHS, daily foetal movement count, BPP/NST).	Doctor on duty /Nursing Staff	
4.4.2 Admission, shifting and referral of pregnant mother.			
A.	• Expectant mother admitted to maternity ward may require shifting to labour room or referral to higher centre any time during their course of stay. • Patient is shifted to labour room when she goes in to labour, or shifted to O.T for CS as per requirement and indication.		
B.	**Patient admitted for surgical intervention:** • A written informed consent is must, duly signed by the patient and attested by doctor on duty. • PAC to be done • Patient is prepared as per the pre-op orders. • O.T. list sent - Anesthetist and O.T. staff informed.		
C.	Patient Transfer Protocol: • Every Hospital should have their own patient transfer protocol/ SOP for transferring pregnant patients. • Decision of transfer should be taken well in advance in case of pregnant patients, when facilities are inadequate and complications are expected. • There must be reasonable ground for transfer of patient. (ground must be recorded in the transfer summary).	Nursing Staff/ Doctor on duty	

	• No patient should be transferred without transfer summary (referral slip for ambulatory and stable patient) • Patient's relatives to be informed and explained about the condition and reasons of transfer as soon as the decision of transfer has been taken. • No hemodynamically unstable patients should be transferred; every effort should be made to stabilize the patient before transferring. • If it is not possible to stabilize the patient, such patients are to be transferred in an adequately equipped ambulance and available trained staff. • It must be for the benefit of the patients. • Consultant must be informed before transferring the patient. • There should be a hospital policy for transferring the patient, with respect to ambulance / doctor and paramedic to accompany the patient. • A record of all transfers to be maintained at department level.(Out referral register) • Transfer summary must contain: o History, clinical examination, investigation reports if any, ECG, X Ray, USG reports, treatment provided. o Reasons for transfer. o What is required, is not available in the transferring hospital. o Whether a formal call to the referral hospital was made, if yes, it should also be recorded in the summary. o If for any reason if it was not possible to contact the referral hospital reasons for the same should also be recorded. o Transfer summary must contain legible name and designation of the transferring doctor. • For EWS patient transfer, the guidelines issued by DHS to be followed. • In case a low risk / manageable patient or their relative wants a transfer, against the advice of doctor it should be recorded in the case sheet and on the discharge summary (DAMA) along with the signatures of the patients / her relatives.		

4.4.3 Shifting of mother to labor room			
	• Expectant mother is admitted in maternity ward and monitored regularly for vitals (PR. BP, RR, FHS, Foetal movements, etc). • Patient should be immediately shifted to LR if there is any sign of onset of labour, maternal or foetal distress, bleeding or leaking. • LR staff should be informed about the condition of the patient, and patient shifted as per the advice of the labour room consultant / SR. • Patient should be shifted in wheel chair/trolley. • Patient should be handed over to the staff of labour room along with all relevant patient record.	Doctor on duty	
4.4.4 Requisition of diagnostics and receiving of the reports.			
	• Requisition for diagnostics as prescribed by the doctor should be followed. • Requisite Lab/USG/ECG form is filled for the patient. • Samples are drawn in appropriate containers, and labeled properly. • Or patient is prepared for testing.(ECG/USG) • Samples are sent to the lab for testing. • Reports are collected from the lab. • Reports are filed in the patient's case sheet, and doctor on duty is informed about the receipt of report.	Doctor on duty/Staff nurse	Refer Annexure-2 of OPD: FORM -F
4.4.5 Preparation of patient for surgical procedure			
A.	• Intimate the staff nurse on duty regarding operation of the patient well in advance. • Date, time and operation theatre number should be clearly written on the patient case sheet. • PAC if not done earlier, should be done prior to surgery, (clearance for anesthesia is required). • An informed consent of the patient or her authorization is taken by the doctor and duly signed by doctor and patient / her relative. • Patient is prepared as per the orders of the surgeon and anesthetist, including: i. Pre-operative investigations (CBC, LFT, KFT, BS –Fasting &PP, CXR, USG, ECG, Coagulation profile). ii. Screening for HBV, HCV and HIV is also desirable. iii. Medication for optimal control of underlying medical disorder.	Doctor on duty Staff nurse	

	iv. Bath one night prior to surgery. v. Grouping and arrangement of blood, pre-op blood transfusion if required. vi. Nil P.O (4-6 hrs fasting). vii. Site preparation/ clipping. viii. Enema/bowel preparation. ix. Site marking if indicated. x. Any special instruction of anesthetist given at the time of pre anesthetic checkup. xi. Pre – operative medications/ including antibiotic as prescribed. xii. Collection of lab reports, ECG, X-Ray, USG reports. xiii. And completing the case record should be done well before posting the patient for operation. • A tentative OT list is sent to the anesthetist a day before the surgery so that he can reassess the patients before surgery and give necessary instructions. • Patient is provided with O.T clothes, (gown / cap) an hour before the surgery. • Patient should be sent to the operation theatre on receipt of message from OT; patients should not be allowed to wait unnecessarily outside the operation theatre. • The case record of the patient should also be • sent to the theatre, and returned to the ward after operation. • The case sheet must have operation notes, post operative prescription/ instructions. • Vitals of the patient to be monitored post operatively. • Special precaution to be taken in ward to prevent any post operative infection.		
4.4.6 Transfusion of blood			
A	**Prerequisite for blood transfusion:** • A doctor's order on the patient case sheet is must for transfusion. • Quantity of blood/component and rate of transfusion must also be prescribed in the case sheet.		

B.	**Informed consent for blood transfusion:** • The patient is informed of the medical indications for the transfusion, the possible risks, the possible benefits, the alternatives and the possible consequences of not receiving the transfusion. • Consent is obtained sufficiently in advance of the transfusion so that the patient can truly understand what is said and has sufficient time to make a choice, whenever feasible. • Consent is documented duly signed by patient/ relative/ doctor/nurse • A single informed consent may cover many transfusions if they are part of a single course of treatment. • It may be advisable, though, to obtain a new consent when there is a significant change in the patient's care status, such as a transfer for care to another service, an inpatient admission, or an outpatient transfusion. • In emergency situations the physician ordering the transfusion must make a reasonable judgment that the patient would accept the transfusion. Transfusion should not be delayed in a life-threatening situation if it is likely that the patient would agree to transfusion. After the event, the circumstances of the transfusion decision should be documented in the case sheet of the patient		

C	• Blood sample of the patient is sent to the blood bank for grouping and cross matching along with blood requisition form (should clearly mention name of the required product and number of units required, sample labels, blood requisition form checked and matched with the patients file). • Availability of requisite product is ascertained from blood bank. • If blood is required at a later time, blood bank is informed and asked to keep the cross matched blood reserved for the patient till such time. • If it is urgent and life saving, it is clearly mentioned in the requisition form. • A blood release form is sent to the blood bank, one bag at a time if no storage facility is available in house. If there is a facility for storage, (Blood bank refrigerator is available) the total quantity of the required blood is to be released from the blood bank.		**Annexure 1-** Checklist for filling Blood Requisition Form

D.	**Receive the blood and verify that:** • Blood is designated for a patient for whom requisition was sent. • Release form bears all the details along with the signature of blood bank staff. • Name and CR number recorded on the release form attached to the unit corresponds with that of the intended patient. • Check, ABO Rh type, patient name/ CR No./ blood bag no and date of expiry of the blood component. • Unit has a normal appearance and is cold. • In case of any discrepancy inform the blood bank immediately, do not transfuse till everything has been clarified from the blood bank. • Record the date and time of receipt of blood bag in the ward on the blood bank release form. • Check the patient case sheet for transfusion order, type, volume and rate of transfusion. • Check if any pre medication is prescribed. Medicate the patient accordingly. • Verify the patient's name, CR No., blood bag for component type/ group/ expiry date. • Check, and record the patient's blood pressure, pulse, respiration and temperature in the chart or on the case sheet with date and time of starting transfusion. • Immediately before transfusion, mix the unit of blood thoroughly by gentle inversion. • If rapid and large volume transfusion is required a blood warmer can be used if available.		**Annexure 2-** Checklist for before starting blood transfusion
E.	**Start transfusion if everything is in order:** • Initial flow rate should be slow not more than 1 ml/minute to allow for recognition of an acute adverse reaction. Proportionately smaller volume for pediatric patients. • If no reaction occurs for first 15 minutes increase the rate to 4 ml / min; usual transfusion time is 2-4 hours, and it should not exceed 4 hours for any component. • Platelets, plasma and cryoprecipitate: 10 ml per minute. The transfusion may be administered as rapidly as the patient can tolerate, usually 30 minutes. • During transfusion monitor the vitals of the patient every 30 minutes (PR, BP, RR, SpO2, temp and any		

	sign of urticaria)
	• Access the flow rate, if unusually slow (less than 3 ml/min.) consider the following to enhance the flow rate.
	  • Repositioning the patient's arm.
	  • Changing to a larger gauge needle.
	  • Changing the filter and tubing.
	  • Elevating the IV pole.
	  • Consider using a transfusion pump, if available.		

F.	**Signs of blood transfusion reaction:** • Hives and itching**:** Are non serious reactions generally controlled by antihistaminic/ steroid and slowing the rate of infusion. • Isolated fever: Developing a fever after a transfusion is not serious. Fever is body's response to the white blood cells in the transfused blood. (slow the rate of infusion.) • However, it can be a sign of a serious reaction if the patient is also experiencing nausea, vomiting, back or chest pain, dark colored urine. STOP TRANSFUSION IMMEDIATELY AND INFORM THE BLOOD BANK AND TREATING DOCTOR. **If a transfusion reaction is suspected** • Stop the transfusion. • Maintain IV with normal saline. • Save the bag and attached tubing, send it to the blood bank for investigation.		**Annexure 3:** Checklist in case of a Blood Transfusion Reaction

G.	**In case of uncomplicated transfusion:** • Record date and time when transfusion was stopped. • Record volume of blood infused. • Document the presence/absence of a transfusion reaction in the patient case sheet. • Discard the blood bag and tubing as per BMW guidelines. • Outpatients or patients who will be leaving the hospital within one week of transfusion should be given written instructions regarding delayed transfusion reactions and asked to report immediately.		
4.4.7 Maintenance of rights and dignity of the patient			
	• Maintenance of women's rights, dignity, privacy and confidentiality is responsibility of every doctor and staff involved in the care of the patient. • Patient's right and responsibilities should be displayed in local language in all patient waiting areas and wards. • Social workers and nurses should also educate the patients about their right and responsibilities. • All doctors and paramedical staff should be made aware of the right and responsibilities of the patients.		
A. A.1 A.2	**Patients rights:** Care: • Patients have a right to receive treatment irrespective of their demographic profile. • Right to be heard regarding her concerns. Confidentiality and Dignity: • Right to personal dignity and to receive care without any form of stigma and discrimination. • Privacy during examination and treatment. • Protection from physical abuse and neglect. • Accommodating and respecting their special needs such as spiritual and cultural preferences.		

A.3	• Right to confidentiality about their medical condition. Information: The information to be provided to patients is meant to be in a language of patient's preference and in a manner that is effortless to understand. • Patients and/ or their family members have the right to receive complete information on the medical problem, prescription, treatment & procedure details. • A documented procedure for obtaining patient's and / or their family's informed consent exists to enable them to make an informed decision about their care. • Patients have to be educated on risks, benefits, expected treatment outcomes and possible complications to enable them to make informed decisions, and involve them in the care planning and delivery process. • Patients or their authorized individuals have the right of access and to get a copy of their clinical records on their written request. Preferences: Patients have a right to seek a second opinion on their medical condition.		
A.4	• Right to information from the doctor to provide the patient with treatment options, so that the patient can select what works best for her.		
B. B.1 B.2	**Patients responsibility**: Honesty in disclosure: • Patients shall be honest with doctor & disclose their complete family/ medical history whenever asked. Treatment compliance: • Patients shall do their best to comply with doctor's treatment plan. • Patients shall have realistic expectations from the doctor and his/her treatment. • Inform and bring to the doctor's notice if it has been difficult to understand any part of the treatment or of the existance of challenges in complying with the treatment.		

B.3	Transparency and honesty: • Patients shall make a sincere effort to understand their therapies which include the medicines prescribed and their associated adverse effects and other compliances for effective treatment outcomes. • If not happy, patient shall inform and discuss with her doctor/ administration. • Patients shall report any fraud and wrong doing by any staff member or person in the hospital.		
B.4	Conduct: • Patients shall be respecting the doctors and medical staff. • Patients shall abide by the hospital / facility rules.		
4.4.8 Record maintenance including taking consent.			
A.1	**Record maintenance in ward:** • A record index should be available in every ward and it should contain: o List of all forms o List of all registers • Management of patient's case sheet. o A separate file is created for every patient admitted to ward. o The cover of the file must contain CR No. / Name/Age / Sex/ and bed number of the patient. o Following forms and documents are to be kept in patient's file in chronological order. o Admission form/ registration forms of the patient. o Clinical notes/ treatment sheets/ progress notes. o Investigation reports o O.T notes o Blood Transfusion notes o Interdepartmental consultation/ referral records. o Discharge/transfer/ death summary of the patient. • The completed records (case sheet of the patient is transferred to MRD after discharge, death and transfer of the patient. • While transferring the records to MRD nursing staff must verify the record is complete in		

A.2	every respect and documents are duly signed by respective doctor. **Management of ward registers:** • All important registers such as admission register, referral register, death register, daily census register etc. are to be transferred to MRD after their completion. Rest of registers such as treatment book, injection register, lab register etc. to be retained and weeded as per the record retention schedule of the hospital.		
B.	**Taking informed consent of patient:** • Informed consent to be taken apart from general form of authorization for medical and surgical management. • Is taken for all surgical procedures, blood transfusion, invasive procedures, etc. • Before any of the above procedure patient and their relatives are informed about the planned procedure in a language they can understand easily. • Preferably in presence of a staff nurse. • They are explained in detail about the procedure, its benefits, risk and available alternatives. • Also explained the risks and complications that may arise on refusing the planned procedure. • All queries of patient and their relatives are to be answered to their need and satisfaction. • After the counseling is complete and patient /and or their relative agree, then only the informed consent is prepared, read aloud to the patient and signed by the patient and witnesses.		
4.4.9 Discharge of patient from maternity ward			
	• All mothers and new borns should provided postnatal care in maternity ward for at least 48 hours for uncomplicated deliveries before their discharge from the maternity ward. • If there is no complication and everything is normal patients are prepared for discharge. • **Counseling of mother before discharge:** All women should be given information about the physiological process of recovery after birth, and	Doctor on duty Staff nurse	

	that some health problems are common, with advice to report any health concerns to a health care professional, in particular: • **Signs and symptoms of PPH:** sudden and profuse blood loss or persistent increased blood loss, faintness, dizziness, palpitations/ tachycardia. • **Signs and symptoms of pre-eclampsia/ eclampsia:** headaches accompanied by one or more of the symptoms of visual disturbances, nausea, vomiting, epigastric or hypochondrial pain, feeling faint, convulsions (in the first few days after birth). • **Signs and symptoms of infection**: fever, shivering, abdominal pain and/or offensive vaginal loss. • **Signs and symptoms of thromboembolism**: unilateral calf pain, redness or swelling of calves, shortness of breath or chest pain. • Women should be counseled on nutrition. • Women should be counseled on hygiene, especially hand washing. • Women should be counseled on birth spacing and family planning. Contraceptive options should be discussed, and contraceptive methods should be provided if requested. • Women should be counselled on safer sex including use of condoms. • In malaria endemic areas and during dengue outbreaks, mothers and babies should sleep under insecticide impregnated bed nets. • All women should be encouraged to mobilize as soon as appropriate following the birth. • They should be encouraged to take gentle exercise and make time to rest during the postnatal period. • Iron and calcium supplementation should be provided for at least six month. • On discharge all mothers are advised and encouraged to visit OPD at least thrice after discharge • 1st visit on day 3 (72 hrs after discharge) • 2nd visit between day 7 to 14. • 3rd visit six weeks after birth.		

4.4.10 Postnatal inpatient care of mother			
	• All mothers and new born should be provided with postnatal care in maternity ward for at least 48 hours for uncomplicated deliveries. • On postnatal care round mother to be assessed and documented for the following: o General condition including pallor. o Pulse, BP and temperature should be recorded immediately after birth and if normal 2nd measurement to be taken within 6 hrs. o Amount of vaginal bleeding. o Uterine tenderness and tone. o Lochia colour and odour. o Condition of perineum. o Calf tenderness. o Condition of the breasts. o Any other complaint (vomiting, fever, headache, blurred vision, excessive abdominal/ perineal pain). o In case of any positive finding, patient to be treated accordingly in the ward.		
4.4.11 Postnatal in-patient care of the newborn.			
	The following signs should be assessed during each postnatal care contact and the newborn should be referred for further evaluation if any of the signs is present: • Stopped feeding well. • History of convulsions. • Fast breathing (breathing rate ≥60 per minute). • Severe chest in-drawing, • No spontaneous movement. • Fever (temperature ≥37.5 °C). • Low body temperature (temperature <35.5º C). • Any jaundice in first 24 hours of life, or yellow palms and soles at any age. The family should be encouraged to seek health care early if they identify any of the above danger signs in-between postnatal care visits. **Breast feeding:** • All babies should be exclusively breastfed from birth until 6 months of age.	Paediatrician Staff nurse	

	• Mothers should be counselled and encouraged for exclusive breastfeeding at each postnatal contact. • Check and reinforce mother's knowledge on positioning and attachment. • Ask whether baby is taking feeds every 2-3 hours • Enquire about any difficulty in breastfeeding • Clean and dry cord care is recommended for newborns in health facilities and at home in low neonatal mortality settings. • Appropriate clothing of the baby for ambient temperature is recommended. This means one to two layers of clothes more than adults, and use of hats/caps. • The mother and baby should not be separated and kangaroo care must be promoted. • Communicating and playing with the newborn should be encouraged. • Immunization should be promoted • Preterm and low-birth-weight babies should be identified immediately after birth and should be provided special care as per advise of the pediatrician.		
4.4.12 Payments and incentive of beneficiary.			
	• Entitlement and incentive schemes of the government should be prominently displayed in concerned areas of the hospital. • Patient and her relative should be informed about all / any ongoing government incentives and benefits. • Patient/ relative should also be informed about the codal formalities for availing the benefits of the scheme, and whom to contact for the benefit. • As all benefits are transferred through DBT online, patient's bank details must be accurately documented.	Family welfare staff/ANM	
4.4.13 Counseling of the patient at the time of discharge.			
A.	**Discharge of patient from ward:** As soon as decision of discharge is taken on account of fitness/ cure/ or improvement of mother and child: **A pre discharge counseling is done for every patient**		

A.1	**to explain the :** • Current condition and the prognosis. It is to be done by senior staff nurse or doctor. • Instruction and what to do in a case of emergency. • Instruction for follow up visits, with days, date/ room number. • Medications and precautions if any. • Do's and Don'ts. • Referrals after discharge if required (such as for management of other medical/ surgical disorders). • This opportunity can also be utilized for getting the feedback of the patient regarding quality of services.	Doctor on duty Staff nurse	**Refer para 4.10 and 4.11 for counseling**
A.2	**Discharge summary must contain the following:** • Date of admission and Date of discharge. • Personal details of the patient. • Diagnosis. • Investigations with reports/results. • Pre-op, operative and post-op notes if any. • Treatment /intervention/ medication provided during the stay. • Advise on discharge should also include medicines, precautions or any special instruction • Instructions for follow-up visits (with day, date and timing).		
A.3	**Death of Patient in Ward** • Doctor on duty should be present at the bed side in case of dying patient along with other paramedical staff. • Doctor will pronounce the patient as dead. • Information must be given clearly to the relatives of the patient buy doctor or nursing staff. • Autopsy to be offered wherever indicated • Death report to be given only after lapse of an hour of pronouncing death • Patient to be covered and cornered in a dignified way, body should be cleaned, chin should be tied, and eye should be closed, and wrapped in mortuary sheet. • Two tags, one around neck and one around		For IPD patient satisfaction survey form Refer **Annexure 4** of SOP Maternity Ward

	wrist is tied in case body is to be kept in mortuary, bearing details of the patient along with date and time of death. • Body to be handed over to the relative after all requisite documentation along with a death summary stating the cause of death. • Nodal Officer MDRC (maternal death review committee) to be informed immediately. • Facility based format as per maternal death review to be filled up and submitted to nodal officer.		
4.4.14 Environmental cleaning, infection control and Processing of equipment			
	These include the following: G. Hand washing and antisepsis (hand hygiene); H. Use of personal protective equipment when handling blood, body substances, excretions and secretions; I. Appropriate handling of patient care equipment and soiled linen; J. Prevention of needle stick/sharp injuries; K. Environmental cleaning(cleaning of surfaces) and spills-management; and L. Appropriate handling of waste (as per biomedical waste management handling rules).		
A.1 A.2	**Wash or decontaminate hands:** • after handling any blood, body fluids, secretions, excretions and contaminated items; • between contact with different patients; • between tasks and procedures on the same patient to prevent cross contamination between different body sites; • immediately after removing gloves. **Antimicrobial soap:** • Used for hand washing as well as hand antisepsis. • If bar soaps are used, use small bars and soap racks, which drain. • Do not allow bar soap to sit in a pool of water as it encourages the growth of some micro-organisms such as pseudomonas. • Clean dispensers of liquid soap thoroughly every day. • When liquid soap containers are empty they must be discarded, not refilled with soap solution.		Refer SOP Labor room annexure 9-pictorial chart for hand washing

A.3	**Specific antiseptics recommended for hand antisepsis:** • 2%-4% chlorhexidine, • 5%-7.5% povidone iodine, • 1% triclosan, or • 70% alcoholic hand rubs. • Waterless, alcohol-based hand rubs: with antiseptic and emollient gel and alcohol swabs, which can be applied to clean hands. Dispensers for hand rub should be placed outside each patient room.		
B B.1	**Use of personal protective equipment** • Health care workers who provide direct care to patients and who work in situations where they may have contact with blood, body fluids, excretions or secretions; • Support staff including medical aides, cleaners, and laundry staff in situations where they may have contact with blood, body fluids, secretions and excretions **Personal protective equipment includes:** • Gloves • Protective eye wear (goggles) • Mask; • Apron; • Gown; • Boots/shoe covers; and • Cap/hair cover. • After use discard the used personal protective equipment in appropriate disposal bags, and dispose of as per the BMW policy of the hospital. • Do not share personal protective equipment. • Change personal protective equipment completely and thoroughly wash hands each time you leave a patient to attend to another patient or another duty.		

C C.1	**Appropriate handling of patient care, equipment handling and soiled linen.** • Handle patient care equipment soiled with blood, body fluids secretions or excretions with care in order to prevent exposure to skin and mucous membranes, clothing and the environment. • Ensure all reusable equipment is cleaned and reprocessed and sterilized appropriately before being used on another patient. • Mattresses with plastic covers should be wiped over with a neutral detergent. • Mattresses without plastic covers should be steam cleaned if they have been contaminated with body fluids. • If this is not possible to decontaminate the bedding it should be removed by manual washing, ensuring adequate personnel and environmental protection. **Linen Handling:** • Place used linen in appropriate bags at the point of generation. • Contain linen soiled with body substances or other fluids within suitable impermeable bags and close the bags securely for transportation to avoid any spills or drips of blood, body fluids, secretions or excretions. Bags to be stored and transported in a leak proof container. • Do not rinse or sort linen in patient care areas (sort in appropriate areas). • Handle all linen with minimum agitation to avoid aerosolization of pathogenic micro-organisms. • Separate clean from soiled linen and transport/store them separately. • Transport and process used linen, and linen that is soiled with blood, body fluids, secretions or excretions in separate leak proof bags with care to ensure that there is no leaking of fluid.	Staff Nurse, Nursing orderly, House keeping staff.	
D.	**Prevention of needle stick/sharps injuries:** • Take care to prevent injuries when using needles, scalpels and other sharp instruments or equipment. • Place used disposable syringes and needles, scalpel		

	blades and other sharp items in a puncture-resistant container with a lid that closes and is located close to the area in which the item is used. • Take extra care when cleaning sharp reusable instruments or equipment. • Never recap or bend needles. • Sharps must be appropriately disinfected and/or destroyed as per the national standards or BMW guidelines.		
E.	**Environmental cleaning(cleaning of surfaces) and spills-management:** • Ward along with all equipments and all surfaces should be cleaned every morning. • All toilets to be cleaned using surface disinfectant at the start of every shift. • The floor and sink should be cleaned with detergent soap at the start of every shift. • Mopping of floors (at the start of every shift/ and sos for spillage). Procedure for mopping described as under. o Clean water is taken in three bucket numbered 1, 2 and 3. o Surface disinfectant is added in bucket no-3(so that 1st and 2nd bucket has clean water and third bucket has disinfectant). o Cleaning of floor begins from inside to outside. Towards the end all corner and groves to be cleaned. o After each sweep of the floor the mop should be dipped first in bucket no. 1, then in no.2 and lastly in no-3 and then floor is mopped again. This process is repeated till the whole area is cleaned. o Water of the three containers to be changed (depending on the size of the ward) as the water in 3rd bucket gets dirty. o Mops to be cleaned in dirty utility area and put in a stand under sun with head of the mop upward, and mops should not be left wet in the ward or any patient area. o After mopping blood or body fluids the mop should be treated as soiled linen and discarded	Staff Nurse/ House keeping staff	

	○ as per BMW guidelines. ○ Mops should be visibly clean before starting cleaning of a ward • Handle patient care equipment soiled with blood, body fluids secretions or excretions with care in order to prevent exposure to skin and mucous membranes, clothing and the environment. • Ensure all reusable equipment is cleaned and reprocessed appropriately before being used on another patient. • Universal safety guideline to be followed by all staff members working in the ward.		
F.	**Handling of general and biomedical waste in wards:** To be done as per the biomedical waste management and handling rules.		Reference- SOP Housekeeping and BMW guidelines and rules
4.4.15 Arrangement of intervention in maternity ward.			
	• There should be adequate arrangement of equipment and instruments in the maternity ward to deal with any prenatal or postnatal emergent situation that may arise • Following equipments and trays should be kept ready in ward and daily checked for its working status / completeness. ○ Emergency tray. ○ Delivery tray. ○ Baby tray ○ Medicine tray ○ Emergency drug tray ○ MVA/EVA tray. ○ PPIUCD tray		Trays in LR - Refer to Annexure: 4 of SOP Labour Room
4.4.16 Sorting and distribution of clean linen to the patients.			
A.	• Clean bedding and clean clothes install psychological confidence in the patients and the public and enhances their faith in the services rendered by the hospital. • Every effort should be made to provide clean and tidy linen to the patients. • Linen management in ward has following components. ○ Maintenance of stock of clean linen. ○ Sorting and distribution of clean linen. ○ Handling of dirty linen. ○ Managing laundry services.	Nursing Staff	
B.	**Maintenance of stock of clean linen:**	Nursing Staff	

	• Adequate stocks of clean linen to be maintained in ward. • Quantity to be calculated on the basis of daily requirement, laundry turn over time and 20% of buffer stock to be added. Calculated as under: • (Stock) = Daily requirement X Laundry turnover days. • Laundry turn over days is number of days laundry takes to clean and return clothes to the ward. • Add 25% to above for buffer and rainy days. • (Example) (calculation for stock of bed sheet to be kept in ward): for a 25 bedded ward , where laundry takes 7 days to return the clothes. • Daily requirement = Number of bed (25) X 7= 175 • Add 25 % = 43.75 (round it to 44) • Stock of bed sheet to be kept in a 25 bedded ward is approximately 219. Similarly a stock of other linen items to be calculated and kept in stock. • Torn and stained clothes to be sorted and condemned as per hospital policy. • Life of linen depends on the quality of fabric, washing methods. • Following quantity of linen is suggested for wards in general. o Bed sheets – 6 -8 per bed. o Pillow cover – 4-6 per bed. o Pillow 2 per bed o Blanket - 3-4 per bed o towel - 2 per bed o draw sheet -6-8 per bed o patient dress 4 pairs o duster 20 per ward o Mortuary sheet 6/ward o Baby sheet 10 per bed. o Mattress cover 2 per bed Note: above requirement is indicative only, requirement can very as per availability of laundry in house, demand /stock to be calculated for individually for every ward for pediatrics ward demand is double.		
C.	**Sorting of laundry:** Linen for laundry to be sorted and kept in separate bags at the point of generation. • **Soiled linen:** are used by patient/ ordinary dirty without urine etc. are collected at source and send for washing (no sorting at source	Nursing Staff	

	required , minimal storage at source) • **Infected linen:** Linen soiled with pus blood, body discharge, Minimum storage at source, sluicing and soaking in disinfectant solution to be done in laundry. • **Foul linen:** Faeces, excretions and blood stained linen to be collected in leak proof containers, and sluicing to be done before washing.		
D.	**Distribution of linen:** • Clean linen is distributed daily during the first shift in the ward. (bed sheets, pillow cover etc require daily change. • Also change linen as and when soiled/ stained. • Patients should be provided with clean and unstained linen. • Torn linen are repaired or discarded immediately, should not be provided to the patients.	Nursing Staff	
4.4.17 Providing free diet to the patient as per their requirement.			
	• Food distribution timing should be displayed prominently in wards. • Patients are to be provided free diet, as per the advise of the dietician or treating doctor. • Special diets such as diabetic diet, low salt diet, high protein diet etc. should be advised in patient's case sheet and nursing staff should also be informed.		Refer SOP Auxillary services: dietetics

Annexures

Annexure 1. Checklist For Filling Blood Requistion Form

1.	All details filled Legibly, in capitals, without any overwriting or cutting	YES / NO
2.	Form Signed by Senior resident	YES / NO
3.	Lifesaving forms signed by faculty/CMO with stamp	YES / NO
4.	Blood Group of patient clearly written on the form	YES / NO
5.	Haemoglobin written on the form	YES / NO
6.	Reason for blood transfusion mentioned	YES / NO
7.	Blood component required mentioned	YES / NO
8.	No of Units clearly mentioned (in words)	YES / NO
9.	Patient correctly identified from case sheet before sample drawing	YES / NO
10.	Sample taken from a vein other than that of an IV line on flow	YES / NO
11.	Sample in plain vial and one EDTA vial(2cc each)	YES / NO
12.	Vial labeling confirmed by Senior Resident	YES/NO

Checklist filled by (Name, Designation, Sign)--

BY S/N or DOD

Annexure 2. Checklist Before Starting Blood Transfusion

Date: Patient: CR NO:

Checklist Before Blood Transfusion

1.	Availability of Emergency Tray and the Drugs ensured	YES / NO
2.	Working Oxygen connection	YES / NO
3.	Working Suction Apparatus at hand	YES / NO
4.	Written Consent obtained from patient or attendant	YES / NO
5.	Correct Patient Identified before transfusion	YES / NO
6.	Patients Name, CR No., Blood group confirmed from case sheet and tallied with that on the Form and the Blood Bag	YES / NO
7.	Blood Bag No. Checked and tallied with that on the form	YES / NO
8.	Date of Collection and date of Expiry checked	YES / NO
9.	Checked whether Patient is in failure or not	YES / NO
10.	Pre Transfusion vital signs checked	YES / NO
11.	Inj. frusemide 20 mg given pre transfusion	YES / NO

Checklist filled by (Name, Designation, Sign)--

BY S/N S. No 1-3:

By DOD S.No.4-11:

3. Checklist In Case of A Blood Transfusion Reaction

Date: Patient: CR NO:

Checklist In Case of Blood Transfusion (Bt) Reaction

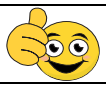
1.	Doctor on Duty Informed	YES / NO
2.	Type of Reaction	
3.	Any Medication Given	YES / NO
4.	Attendents Informed about BT Reaction	YES / NO
5.	Time of Reaction from the start of BT	
6.	Amount of blood transfused since than (in ml)	
7.	Immediate Post Transfusion Reaction blood sent to blood bank (Plain vial + EDTA vial)	YES / NO
8.	Blood Bag and BT set sent to Blood Bank	YES / NO
9.	First specimen of urine voided after reaction sent for microscopic haematuria to lab	YES / NO

Checklist filled by (Name, Designation, Sign)-

Source: Modified from WHO checklists for blood transfusion

4.IPD Patient Feedback Schedule

आई0पी0डी0 रोगी फीडबेक फॉर्म

	सूचक	निम्न स्तरीय 	सामान्य 	अच्छा 	बहुत अच्छा 
1	अस्पताल में विभिन्न सेवाओं/विभागों तक पहुॅचने के लिए सूचना बोर्ड का यथाचित प्रदर्शण				
2	पंजीकरण कराने में कुल समय	30 मिनट से ज्यदा	11–30 मिनट	5–10 मिनट	5 मिनट मे
3	रजिस्ट्रेशन काउंटर में अस्पताल के कर्मचारियों का व्यवहार				
4	डिस्चार्ज प्रक्रिया का अनुभव (यदि सतुष्ट नही तो नीचे सुझाव दें)				
5	वार्ड की साफ–सफाई का अनुभव				
6	शौचालय व स्नानघर की साफ–सफाई				
7	चादर/बेड तकिया कवर की स्वच्छता				
8	अस्पताल परिसर व नालियों की साफ–सफाई				
9	डॉक्टरों द्वारा नियमित जांच व देखभाल				
10	डॉक्टरों द्वारा मरीज के प्रति व्यवहार				
11	जांच/परामर्श, सलाह में दिये गये समय से संतुष्टि				
12	सेवा उपलब्ध कराने में नर्सों की शीध्रता व सजगता				
13	वॉर्ड में 24 घंटे नर्सों की उपलब्धता				
14	नर्सों द्वारा मरीज के प्रति व्यवहार				
15	वॉर्ड बॉय/महिला (कर्मचरियों) की उपलब्धता व उनका मरीज के साथ व्यवहार				
16	अस्पताल में दवाई की उपलब्धता				
17	अस्पताल में लेब जांच, एक्सरे इत्यदि की उपलब्धता				
18	अस्पताल में भोजन वितरण की समयबद्धता				
19	अस्पताल में दिये गये भोजन की गुणवत्ता				
20	अस्पताल में दिये गये उपचार व सेवाओं से संतुष्टि				

1 इस अस्पताल व इसकी सेवाओं में सुधार के लिए सुझाव

2 क्या आप इलाज के लिए इस अस्पताल की सेवाओं को पुनः प्राप्त करना चाहेंगे यदि हॉ तो क्यों?

यदि नही तो क्यों? दिनांकः आयुः लिंगः पुरूष/महिला आई0पी0डी0 नम्बरः
फोन न0

5. Contents Of 7 Trays In Labour Room

Source: Modified from "Guidelines for Standardization of Labor Rooms at Delivery Points", Ministry of H&FW, Govt. of India, March 2016.

Tray 1: Delivery Tray

	Content		**Content**
1.	Gloves	2.	Scissors
3.	Artery forceps	4.	Cord clamp
5.	Sponge holding forceps	6.	Urinary catheter & Urobag
7.	Bowl for antiseptic lotion	8.	Gauze pieces
9.	Cotton swabs	10.	Speculum
11.	Sanitary pads	12.	Kidney tray
13.	Sterilized linen	14.	Kelley's pad

Tray 2: Episiotomy Tray

Routine episiotomy is not recommended. However, it is desirable to keep the episiotomy tray ready in case of need.

	Content		**Content**
1.	2% Inj. Xylocaine	2.	10 ml disposable syringe and needle
3.	Episiotomy scissors	4.	Kidney tray
5.	Artery forceps	6.	Allis forceps
7.	Sponge holding forceps	8.	Toothed forceps
9.	Needle holder	10.	Thumb forceps
11.	Sim's speculum	12.	Round body and cutting needle
13.	No. 0 Chromic catgut/ Polygalactin rapid no 0 or 2 0	14.	Gauze pieces
15.	Cotton swabs	16.	Gloves
17.	Antiseptic lotion	17.	Sterilized linen/gynae sheet

Tray 3: Baby tray

	Content		**Content**
1.	Pre-warmed towel/sheets	2.	Cotton swabs
3.	Mucus extractor	4.	Bag and mask
5.	Sterilized thread for cord or cord clamp	6.	Nasogastric tube
7.	Gloves	8.	In. Vit. K
9.	Needle and syringe	10.	Pre-warmed receiving baby sheet

Tray 4: Medicine tray

	Content		Content
1.	Inj. Oxytocin 10 IU – pre loaded	2.	T. Misoprostol 200 mcg
3.	Inj. PG F2 alpha	4.	Inj. Methylergometrine
5.	Cap. Ampicillin 500 mg	6.	T. Metronidazole 400 mg
7.	T. Ibuprofen	8.	T. B-complex
9.	T. Paracetamol	10.	Inj. Gentamycin
11.	Inj Dexamethasone	12.	Inj. Betamethasone
13.	Ringer lactate	14.	Normal saline
15.	Inj. Hydralazine	16.	Inj Labetolol
17.	T. Methyldopa	18.	Cap. Nifedipine
19.	Inj. Vit K	20.	Magnifying glass

Tray 5: Emergency tray for Labor Room and Maternity Ward

	Content		Content
1.	Inj. Adrenaline	2.	Inj. Diazepam
3.	Inj. Calcium gluconate 10%	4.	Inj. Atropine
5.	Inj. Soda Bicarbonate	6.	Inj. Hydrocortisone Succinate
7.	Inj. Pheniramine maleate	8.	Inj. Lignocaine 2%
9.	Inj. Magsulf 50%	10.	Inj. PG F2 alpha
11.	Inj. Labetolol/Inj . Hydralazine	12.	Ringer lactate
13.	Normal Saline	14.	IV sets with two 16-guage needles
15.	IV Cannula	16.	Vials for drug collection
17.	Controlled suction catheter	18.	Mouth gag
19.	Foleys catheter	20.	Urobag
21.	Endotracheal tube	22.	Ambu Bag and Mask
23.	Laryngoscope	24.	Defirillator AED device

Tray 6: Evacuation / D&E tray

	Content		Content
1.	Gloves	2.	Cusco's Speculum
3.	Anterior vaginal wall retractor	4.	Sim's Speculum
5.	Sponge holding forceps	6.	Suction Cannula different sizes
7.	Stainless steel bowl	8.	Antiseptic lotion
9.	Endometerial curette	10.	Hegar's cervical dilator set
11.	Sanitary pads	12.	Cotton swabs or pads
13.	Disposable syringe and needle	14.	Sterilised gauze/pads
15.	Urobag	16.	Foley's catheter
17.	T . Misoprostol	18.	Inj. Oxytocin
19.	In. Methylergometrine	20.	Sterilized linen

Tray 7: PPIUCD TRAY

	Content		**Content**
1.	PPIUCD insertion forceps	2.	Cu IUCD 380A or 375
3.	Sim's speculum	4.	Sponge holding forceps
5.	Stainless steel bowl	6.	Sterilized linen
7.	Antiseptic solution	8.	Gloves

5. FAMILY PLANNING CLIENTS

5.1 Purpose:

To accomplish management of Family Planning (FP) client.

5.2 Scope:

Patient attending family planning OPD & requiring MTP/ temporary/ permanent method of contraception/ emergency contraception.

5.3 Responsible Person:

Doctor on Duty/ Staff Nurse/ ANM.

5.4Procedure:

Sr. No.	Activity	Responsibility	Reference
5.3.1 Registration			
	Separate registration of Family Planning client.	Registration Clerk	
5.3.2 Initial assessment of patient			
	• Patient goes to Family Planning OPD where history taking is followed by detailed general / systemic examination and services required by patient established. • Cafeteria choice offered & necessary forms to be filled accordingly.	Doctor on duty/ Nursing Staff/ ANM	
5.3.3 Temporary method of contraception			
A.	Patient seeking temporary method of contraception are managed on OPD basis as per need. **Condom:** • Counseling regarding correct use. • Preferable with spermicidal jelly. • Benefits & failure rate to be explained.	Doctor on duty/ Nursing Staff/ ANM	
B.	**Oral Contraceptive Pills:** 1.Combined Pills 2. Progesterone		MEC criteria

C.	only pills 3. Emergency contraceptives 4. Others. • Selection as per MEC criteria. • Counselling to be done about effectiveness & side effects. • Regular intake of doses to be emphasized and query regarding missed dose to be explained. **Intrauterine contraceptive device:** • Assess suitability as per MEC criteria. • Timings - Post menstrual - Post abortal - Post delivery • Method of insertion as per GOI guidelines. • Follow up & counseling (1 week – 4 week – 6 Month – 1 year) • Index card to be given		MEC criteria see website: nrhm.gov.in2016 GOI . IUCD reference manual for medical officers, **Annexures: 1,** IUCD insertion/removal tray **Annexures:7 & 8 ,** Consent forms: insertion/removal **Annexures: 7 (a),** IUCD follow up card
5.3.4 Permanent method of contraception			
A.	**Female Sterilization:** • Selection of patient to be done • It can be done laparoscopic/ interval/ minilap/with caesarean section. • Admission in hospital. • Preop Investigation: - Hb, blood gp, urine test as per GOI guidelines. USG not mandatory. Rest investigations tailored as applicable. • Consent and counseling. • Anesthesia fitness. • Procedure to be done by empanelled doctor. • OT notes to be signed by operating doctor. • Discharge only after assessment. • Advise during discharge. • Follow up 7 days, 14 days, 1 Month.	Empanelled doctors/ANM	GOI Guidelines: Standards for Female and Male Sterlization Services **Annexures:6,** • Checklist for sterilization **Annexures: 5,** • Consent form for male/female sterilization

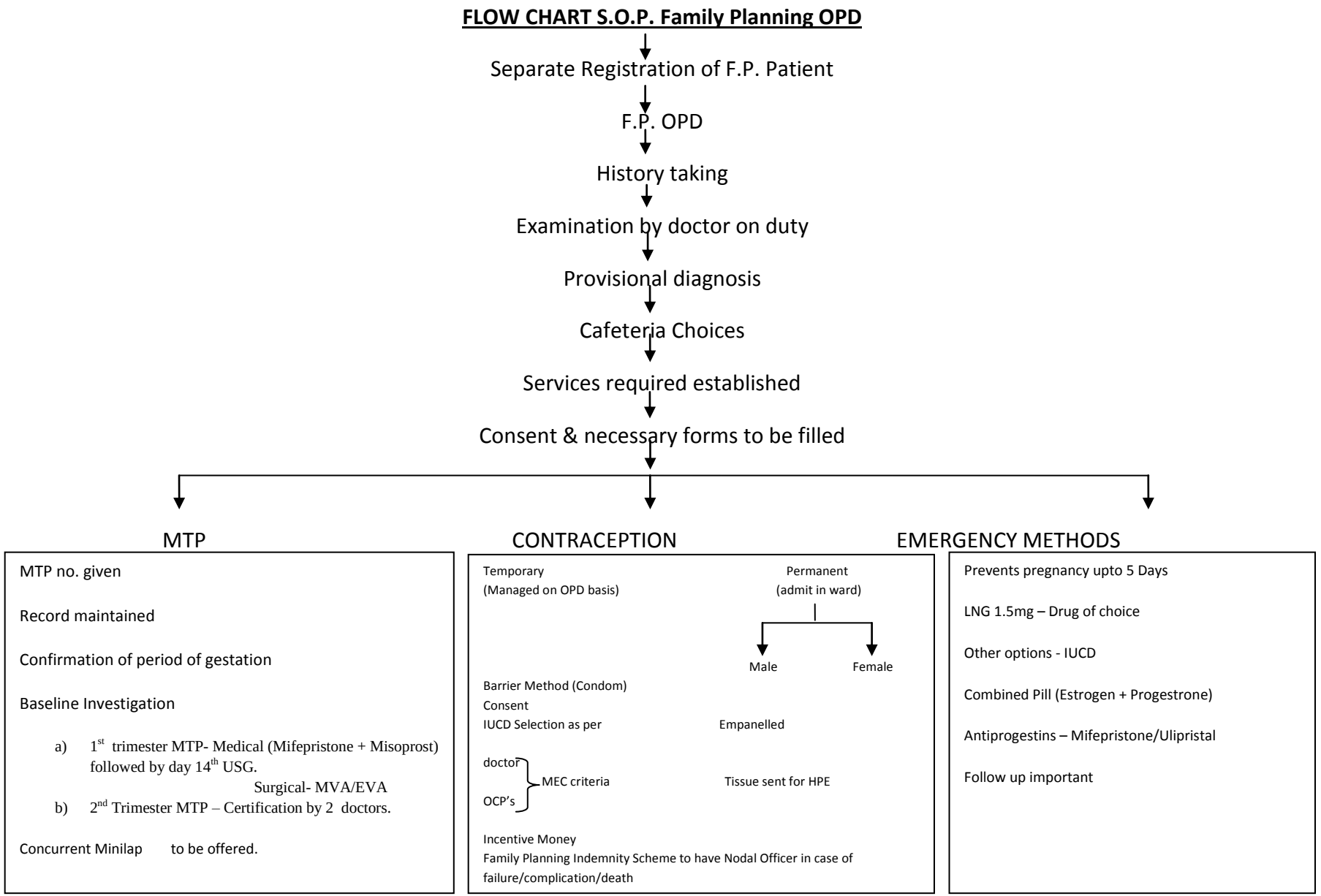
B.	• Certificate to be collected from family planning department. • Incentive money as per GOI policy. **Male Sterilization:** • Non scalpel vasectomy (NSV). • Day care surgery. • Consent and counseling. • To be done by empanelled doctor • Certificate to be collected after 3 months after semen analysis report. Incentive money distribution as per GOI policy.	Empanelled doctors	

5.3.5 Family planning indemnity scheme(FPIS)			
	• In case of failure/complication/death detailed document to be forwarded to competent authority. • Appoint a Nodal officer (preferably Family Planning Incharge) • Manual for FPIS to be kept in FP department and with H.O.D	Family Planning Incharge	Website for guidelines: nrhm.gov.in Quality Assurance Manual for Sterilization Services
5.3.6 Medical Termination of Pregnancy (MTP)			
	• Patient selection to be done. • Allot MTP number. • Confirm period of gestation. • Assignment of method of MTP after patient counseling. • Consent form should be duly signed and attested.	Empanelled Doctor/ Nursing Staff/ ANM	MTP ACT, Medical Termination Of Pregnancy Regulations, 2003 MH&FW (DFW)
A.	**Ist Trimester MTP:**		
A.1	**Medical Method Abortion (MMA)** • Baseline investigations to be done (Hb, urine test, USG desirable) • Prescription of drugs as per GOI		**Annexure:2,** Consent form for MTP by MMA

A.2	guidelines (Mifepristone + Misoprost). • Counseling of side effects & follow up. • Day 14 USG. • Post abortal contraception counseling. **Surgical Method** • Baseline investigations to be done. • Date for surgery to be taken. • Consent form to be filled (Form C, Form I). • Pre procedural cervical ripening desirable (400 ugm misoprost 2-4 hrs prior to procedure). • Procedure – MVA/EVA • Counseling done at discharge. • Concurrent contraception to be given (IUCD/Ligation).		www.nrhm.gov.in CAC providers manual **Annexure:3,** MTP: Consent Form C & I
B.	**IInd Trimester MTP:** • Admit patient. • Certification by 2 doctors. • Choose the correct method. • Concurrent ligation (minilap) to be offered. • Contraceptive follow up after 1wk/SOS.		Ministry of H&FW, GOI. nrhm.gov.in CAC Providers Manual
5.3.7 Emergency Contraceptive			
A.	• Suitability to be assessed. • Works best when used within 24hrs of unprotected intercourse but prevents pregnancy even upto 5 days. • Choice given- - LNG (1.5 mg) drug of choice. - IUCD -Combined pill- estrogen+ progesterone (Yuzpe regimen) • Antiprogestins-Mifepristone /ulipristal. • Follow up must after next period / missed period. • Counseling for regular contraception.	Doctor / Nursing sister/ ANM	

B.	MTP Act, Guidelines of medical abortion, manual for male and female sterilization and manual for quality assurance for sterilization to be kept in family planning department.		

FLOW CHART PPU



Annexure

Annexure 1. IUCD Insertion/ Removal Tray

S.NO.	CONTENTS	S.NO	CONTENTS
1.	IUCD 380A	2.	IUCD 375
3.	Sim's speculum	4.	Anterior vaginal wall retractor
5.	Volsellum	6.	Uterine sound
7.	Artery forceps	8.	Suture cutting scissors
9.	Stainless steel bowl	10.	Cotton swabs
11.	Antiseptic solution	11.	Gloves

Annexure 2. Consent Forms For MTP by MMA

Source: Website for detailed information: http://nrhm.gov.in/nhm/nrhm/guidelines/nrhm-guidelines/family-planning-guidelines.html

CONSENT FORM OF MTP BY MMA

I have been explained about the process of medical method of abortion, which is a method to terminate pregnancy using a combination of two medicines. I understand that I will be require to take the prescribe doses of Mefepristone on day 1 followed by Misoprostol on day 3. I also understand that I will be required to come to the clinic for a follow a visit on day 15 to confirm the completion of the procedure.

I understand that many women experience some side effects with medical method of abortion such as nausea, vomiting, diarrhea, abdominal pain, cramping and bleeding. The bleeding may be heavier than I usually experience during my menstruation.

My doctor / counselor has also explained that there are chances that the method may failed to terminate the pregnancy. In such a situation, it will be necessary for me to undergo a surgical abortion to complete the process. If I experience any symptoms identified by my doctor as danger sign, or if I have any concern about the procedure during the course of 15 days, I may call my doctor.

I _____ D / W / o _____ age about ____

Years, residing at (Address) _____

Do hereby give my consent for termination of pregnancy at _____

Place :

Date: SIGNATURE

I _____ D / W / o _____ age about ____

Years, residing at (Address) _____

Do hereby give my consent for termination of pregnancy of my ward at _____

Place :

Date: **Signature**

MMA Client Card

In case of emergency please contact	Detail of patient
Doctor	Name :
Ph. No.	Ph. No.:
Hospital address :	Residential address :
	Date of first visit :
	Date of Second visit :
	Date of third Visit :

Annexure **3. [A] MTP : Consent Form C & I**

FORM C (See rule 9)

I _____ daughter / wife of _____

aged about _____ years at present residing at _____ (state the permanent address) do hereby give my consent to termination of my pregnancy at _____ (state the name of place where pregnancy is to be terminated)

Place_____
Date _____

Signature / Thumb impression _____

(to be filled in by guardian where the woman is mentally ill person or minor)

I _____ son / daughter / wife of_____ aged about _____ years at present residing at (Permanent address) _____

_____

do hereby give my consent to the termination of the pregnancy of my ward _____ who is a minor / mentally ill person at _____(place of termination of pregnancy)

Place _____

Date _____

Signature / Thumb impression _____

FORM I [See Regulation 3]

I_____

(Name and qualifications of the Registered Medical practitioner in block letters)

_____

(Full address of the Registered Medical practitioner)

I_____

(Name and qualifications of the Registered Medical practitioner in block letters)

_____

(Full address of the Registered Medical practitioner) hereby certify that *I/We am/are of opinion, formed in good faith, that it is necessary to terminate the pregnancy of

_____

(Full name of pregnant women in block letters) resident of

_____

(Full address of pregnant women in block letters)

for the reasons given below**.

* I/We hereby give intimation that *I/We terminated the pregnancy of the woman referred to above who bears the serial no. _____ in the Admission Register of the hospital/approved place.

Signature of the registered Medical Practitioner

Signature of the registered Medical Practitioners

Place :

Date :

*Strike out whichever is not applicable,

** of the reasons specified items

(i) to (v) write the one which is appropriate.

(i) in order to save the life of the pregnant women,

(ii) in order to prevent grave injury to the physical and mental health of the pregnant women,

(iii) in view of the substantial risk that if the child was born it would suffer from such physical or mental abnormalities as to be seriously handicapped,

(iv) as the pregnancy is alleged by pregnant women to have been caused by rape,

(v) as the pregnancy has occurred as result of failure of any contraceptive device or methods used by married woman or her husband for the purpose of limiting the number of children

Note : Account may be taken of the pregnant women's actual or reasonably foreseeable environment in determining whether the continuance of her pregnancy would involve a grave injury to her physical or mental health.

Place :

Date :

Signature of the Registered Medical Practitioner

Signature of the Registered Medical Practitioners

Annexure 4. [B] STERILIZATION :

a). Checklist

Source: Sterlization Checklist, Quality Assurance Manual for Sterlization Services, , Ministry of H&FW, GOI, 2006,

b). Consent form

Informed consent form for Sterilization Operation /Resterlization. Annexure 4, Standards for Female and Male Sterlization Services, Oct 2006

Annexure - VII

MEDICAL RECORD & CHECK LIST FOR FEMALE / MALE STERILIZATION

(TO BE FILLED BEFORE COMMENCING THE OPERATION)

NAME OF HEALTH FACILITY: .....

BENEFICIARY REGISTRATION NUMBER: ..... DATE: .....

A. ELIGIBILITY

Client is within eligible age	Yes..... No.....
Client is ever married	Yes..... No.....
Client has at least one child more than one year old	Yes..... No.....
Lab investigations (Hb, urine) undertaken are within normal limits	Yes..... No.....
Medical status as per clinical observation is within normal limits	Yes..... No.....
Mental status as per clinical observation is normal	Yes..... No.....
Local examination done is normal	Yes..... No.....
Informed consent given by the client	Yes..... No.....
Explained to the client that consent form has authority as legal documen	Yes..... No.....
Abdominal / pelvic examination has been done in the female and is WNL	Yes..... No.....
Infection prevention practices as per laid down standards	Yes..... No.....

B. MEDICAL HISTORY

	Recent medical Illness	Yes.....	No.....
	Previous Surgery	Yes.....	No.....
	Allergies to medication	Yes.....	No.....
	Bleeding Disorder	Yes.....	No.....
	Anemia	Yes.....	No.....
	Diabetes	Yes.....	No.....

	Jaundice or liver disorder	Yes…… No……
	RTI/STI/PID	Yes…… No……
	Convulsive disorder	Yes…… No……
	Tuberculosis	Yes…… No……
	Malaria	Yes…… No……
	Asthma	Yes…… No……
	Heart Disease	Yes…… No……
	Hypertension	Yes…… No……
	Mental Illness	Yes…… No……
	Sexual Problems	Yes…… No……
	Prostatitis	Yes…… No……
	Epididymitis	Yes…… No……
	H/O Blood Transfusion	Yes…… No……
	Gynecological problems	Yes…… No……
	Currently on medication (if yes specify)	Yes…… No……
	LMP	Date:

Comments……..
……
……

C. PHYSICAL EXAMINATION

BP……Pulse……..Temperature……..

	Lungs	Normal…… Abnormal……
	Heart	Normal…… Abnormal……
	Abdomen	Normal…… Abnormal……

D. LOCAL EXAMINATION

1. MALE STERILIZATION

	Skin of Scrotum	Normal…… Abnormal……
	Testis	Normal…… Abnormal……
	Epididymis	Normal…… Abnormal……
	Hydrocele	Yes…… No……
	Varicocele	Yes…… No……
	Hernia	Yes…… No……
	Vas Deferens	Normal…… Abnormal……
	Both Vas Palpable	Yes…… No……

2. FEMALE STERILIZATION

	External Genitalia	Normal…….. Abnormal……
	PV Examination	Normal…….. Abnormal……
	PS Examination	Normal…….. Abnormal……
	Uterus Position	A/V…… R/V…….. Mid position…….. Not determined……
	Uterus size	Normal…….. Abnormal……
	Uterus Mobility	Yes…… No……
	Cervical Erosion	Yes…… No……..
	Adnexa	Normal…….. Abnormal……

Comments……..
……
……

E. LABORATORY INVESTIGATIONS

	Hemoglobin level	……Gms%	
	Urine: Albumin	Yes……1 No……2	
	Urine- Sugar	Present……1 Absent……2	
	Urine test for Pregnancy	Positive: ……. Negative: ……..	
	Any Other (specify)	…… ……	

Name:

Signature of the Examining Doctor

HOSPITAL SEAL

Date:

Annexure 5. CONSENT FORM (Sample) FOR MALE/FEMALE STERLIZATION

परिवार कल्याण निदेशालय
दिल्ली सरकार

उपाबंध –1

<u>नलबंदी/नसबंदी ऑपरेशन के लिए आवेदन तथा सूचित किया गया सहमति पत्र</u>

स्वास्थ्य केन्द्र का नाम ..... तारीख .....
लाभ ग्राही की अस्पताल पंजीकरण संख्या .....
1. स्वीकृति कर्ता का नाम श्री/श्रीमती .....
2. पति/पत्नी का नाम श्री/श्रीमती .....
3. पता .....
.....
4. दूरभाष नं0..... मोबाईल.....
5. सभी जीवित, अविवाहित, आश्रित, बच्चों के नाम

i. ..... आयु .....
ii. ..... आयु .....
iii. ..... आयु .....
iv. ..... आयु .....
v. ..... आयु .....
vi. ..... आयु .....

6. लाभग्राही के पिता का नाम : श्री .....
7. पता .....

8. धर्म/राष्ट्रीयता .....
9. जाति एस0सी0,एस0टी0,बी0सी0,जनरल .....
10. स्तर ए0पी0एल0/बी0पी0एल0 .....
11. शैक्षणिक योग्यता .....
12. व्यापार/व्यवसाय .....
13. शल्य केन्द्र .....

मैं, श्री/श्रीमती ..... (लाभग्राही का नाम) अपने नलबंदी/नसबंदी **ऑपरेशन** करवाने हेतु सहमति देता/देती हूँ। मैं विवाहित/कभी विवाहित हूं। मेरी आयु ..... **वर्ष** है तथा मेरे पति/पत्नी की आयु ..... वर्ष है। हमारे ..... जीवित लड़के तथा .जीवित लड़कियां हैं। मेरे सबसे छोटे जीवित बच्चे की आयु ..... वर्ष है।
मैनें यह नलबंदी/नसबंदी ऑप्रेशन/पुनः नलबंदी/नसबंदी बिना किसी बाहरी दबाव, लालच या जबरदस्ती के अपनी स्वेच्छा से करवाने का निर्णय लिया है। मेरे पति/पत्नी ने पहले कोई नसबंदी/नलबंदी ऑप्रेशन नहीं करवाया। (पुनः नलबंदी/नसबंदी के लिए लागू नहीं) (.....)

1. मुझे पता है कि गर्भ निरोध के अन्य तरीके भी उपलब्ध हैं। मैं यह जानता/जानती हूँ कि यह **ऑपरेशन** मूलतः स्थायी है। मुझे यह भी पता है कि **ऑपरेशन** के असफल होने के भी कुछ अवसर हो सकते हैं जिसके लिए **ऑपरेशन** करने वाला

डॉक्टर/स्वास्थ्य सुविधा को मेरे सम्बंधियों द्वारा या मेरे द्वारा या किसी भी अन्य व्यक्ति, जो भी हो, द्वारा उत्तरदायी नहीं ठहराया जाएगा। (.....)

2. मुझे इस बात की जानकारी है कि मैनें जो **ऑपरेशन** करवाना है उसके जोखिम का तत्व हो सकता है।
पण (.....)

3. मुझे **ऑपरेशन** के लिए पात्रता मापदंड स्पष्ट कर दिए गए हैं तथा इस बात की पुष्टि करता/करती हूँ कि मापदण्ड के अनुसार **ऑपरेशन** कराने का/की पात्र हूँ। (.....)

4. मैं किसी भी प्रकार की एनसथिसिया (**बेहोशी**) के अन्तगर्त ऑप्रेशन करवाने के लिए सहमत हूँ (जिसे डॉक्टर/स्वास्थ्य सुविधा मेरे लिए उचित समझे) तथा जो डॉक्टर/सम्बंधित स्वास्थ्य सुविधा द्वारा दी जाने वाली अन्य दवाईयाँ उचित समझी जाए, ग्रहण करने के लिए सहमत हूँ। मैं किसी भी सहायक जीवन रक्षक कार्यप्रणाली के लिए भी सहमत हूँ यदि आवश्यक हुआ। (.....)

5. मैं **निर्देशानुसार** अस्पताल/संस्था/चिकित्सक/स्वास्थ्य सुविधा केन्द्र में तत्पश्चात् जाँच हेतु आने के लिए सहमत हूँ, असफल रहने पर परिणाम, यदि कोई हो, के लिए जिम्मेदार रहूंगा/रहूंगी (.....)

6. यदि नलबंदी/नसबंदी ऑप्रेशन के पश्चात् मेरे /मेरी पत्नी का मासिक चक्र समय पर नहीं आता तो मैं डॉक्टर/स्वास्थ्य सुविधा को दो सप्ताह के अंदर सूचित करूंगी/करूंगा तथा **निशुल्क** गर्भपात की सुविधा प्राप्त कर सकूंगा/सकूंगी। मैं परिणाम, यदि कोई हो, के लिए जिम्मेदार रहूंगा। (.....)

7. मैं समझता हूँ कि पुरूष नसबंदी तत्काल बंध्याकरण में प्रभावी नहीं होता है। 'मैं नसबंदी सर्जरीकी सफलता की पुष्टि (एजूस्पर्मिया) के लिए शल्य क्रिया के तीन महीने के बाद वीर्य विश्लेषण के लिए आने को सहमत हूँ तथा आने में असफल रहने पर परिणाम, यदि कोई हो, के लिए स्वयं जिम्मेवार रहूंगा। **('केवल पुरूष नसबंदी के लिए लागू)**
(.....)

8. यदि नलबंदी/नसबंदी **ऑपरेशन** के कारण कोई जटिलता/असफलता अथवा मृत्यु की **अप्रत्याशित** घटना होती है, उस स्थिति में सरकार की श्परिवार नियोजन क्षतिपूर्ति योजनाश के अंतगर्त जितनी **धनराशि** हर्जाने के रूप में सरकार द्वारा दी जाएगी उपरोक्त **राशि** मुझे पति/पत्नी मेरे आश्रित, अविवाहित संतान को पूर्ण और अंतिम निपटान के रूप में स्वीकार्य होगी। यदि मैं /मेरी पत्नी नसबंदी **ऑपरेशन** की विफलता के **पश्चात्**, गर्भवती होती है तब में इस सम्बंध में किसी भी अन्य कानून की अदालत के अंतगर्त परिवार नियोजन बीमा योजना के अंतगर्त मुआवजे से अतिरिक्त **राशि**, अन्य मुआवजे के दावे या बच्चे को पालने के लिए किसी मुआवजे का दावा करने का हकदार नहीं हूँगा/हूँगी।
(.....)

मैनें उपरोक्त जानकारी पढ़ ली है। उपरोक्त सूचना पढ़ कर मेरी **भाषा** में स्पष्ट रूप से समझा दी गई है और इस प्रारूप को कानूनी दस्तावेज का प्राधिकार है।

मुझे ज्ञात है कि मैं किसी भी समय नलबंदी/नसबंदी **ऑपरेशन** करवाने से इंकार कर सकता/सकती हूँ और इससे मुझे मिलने वाली अन्य प्रजनन सम्बंधी सुविधाओं पर कोई प्रभाव नहीं पड़ेगा।

तारीख ..... स्वीकृति कर्ता के हस्ताक्षर/अंगूठा

पूरा नाम .....

गवाह (लाभ ग्राही की तरफ से) के हस्ताक्षर .....

पूरा नाम .....

पूरा पता .....

मुझे पता है कि लाभग्राही विवाहित है/कभी **शादी** की थी और उसका एक जीवित बच्चा एक **वर्ष** से उपर है।

आशा/सलाहकार/प्रेरक के हस्ताक्षर .....
पूरा नाम .....
पूरा पता .....

मैं प्रमाणित करता हूँ कि मैंनें स्वयं को इस बात से संतुष्ट कर लिया है कि : –

6. CHECK LIST FOR STERLIZATION

Medical Record & Checklist for Female and Male Sterilization.

This checklist is to be filled by the doctor before commencing the sterilization procedure for ensuring the eligibility and fitness of the client for the sterilization.

Name of the Facility:

Beneficiary Registration No.:

Date:

A. Eligibility Checklist

Client is within eligible age	Yes……..No……..
Client is ever married	Yes……..No……..
Client has at least one child over one year of age	Yes……..No……..

Lab investigation (HB, urine) undertaken are within normal limits (7.0 gms or more)	Yes……..No……..
Medical status as per clinical observation is normal	Yes……..No……..
Local examination done is normal	Yes……..No……..
Informed consent given by the client	Yes……..No……..
Explained to the client that consent form has authority of a legal document	Yes……..No……..
Infection prevention practices as per laid down standards	Yes……..No……..

B. Menstrual Hygiene (for female clients)

Cycles Days	
Length	
Regularity	Regular……Irregular……..
Date of LMP (DD/MM/YYYY)	……../……/…….

C. Obstetric History (for female clients)

Number of spontaneous abortions	
Number of induced abortions	
Currently lactating	Yes……..No……..
Amenorheic	Yes……..No……..
Weather pregnant	Yes……..No…….. If yes (no. of weeks pregnancy)……..
No. of children	Total no……..
Date of Birth of Last Child (dd/mm/yyyy)	……../……/……

D. Contraceptive History

Have you or your spouse ever used contraceptives?	Yes……..No……..
Are you or your spouse currently using any contraception or have you or your spouse used any contraception during the last six months? (√) *Tick the option*	• None…… • IUCD…… • Condoms…… • Oral Pills…… • Any other (specify)……

E. Medical History

Recent Medical illness	Yes……..No……..
Previous surgery	Yes……..No……..
Allergies to medication	Yes……..No……..
Bleeding disorder	Yes……..No……..
Anemia	Yes……..No……..
Diabetes	Yes……..No……..
Jaundice or liver disorder	Yes……..No……..
RTI/STI/PID	Yes……..No……..
Convulsive disorder	Yes……..No……..
Tuberculosis	Yes……..No……..
Malaria	Yes……..No……..
Asthma	Yes……..No……..
Heart disease	Yes……..No……..
Hypertension	Yes……..No……..
Mental Illness	Yes……..No……..
Sexual Problems	Yes……..No……..
Prostatitis (Male sterilization)	Yes……..No……..

Epididymitis (Male sterilization)	Yes……..No……..
H/O Blood Transfusion	Yes……..No……..
Gynecological problems (Female Sterilization)	Yes……..No……..
Currently on medication (female sterilization)	Yes……..No……..

Comments:……
…….
.....
……
……

F. Physical Examination:

BP……Pulse…….. Temperature……

Lungs	Normal……Abnormal……..
Heart	Normal……Abnormal……..
Abdomen	Normal……Abnormal……..

Physical Examination:

1. Male Sterilization

Skin of Scrotum	Normal……Abnormal……..
Testis	Normal……Abnormal……..
Dpididymis	Normal……Abnormal……..
Hydrocele	Yes……..No……..
Varicocele	Yes……..No……..
Hernia	Yes……..No……..
Vas Defrenes	Yes……..No……..
Both Vas Palpable	Yes……..No……..

2. Female Sterilization:

External Genitalia	Normal……Abnormal……..
PS Examination	Normal……Abnormal……..
PV Examination	Normal……Abnormal……..
Uterus Position	A/V……R/V……. Mid Position……..Not determined……
Uterus size	Normal……Abnormal……..
Uterus Mobility	Yes……..No……(Restricted/Fixed)
Cervical Erosion	Yes……..No……..

Adnexia	Normal……Abnormal……..

Comments……
……
……
……

G. Laboratory Investigations

Hemoglobin Level	……gms%
Urine: Albumin	Yes……..No……
Urine- Sugar	Present……Absent……..
Urine test for Pregnancy	Positive……Negative……
Any other (specify)	…….

Name…… Signature of the examining doctor

Date…… HOSPITAL SEAL

H. Preoperative preparation

Fasting	Yes…… duration…….hrs No…….
Passed urine	Yes……..No……
Any other (specify)	

Anesthesia/Analgesia

Type of anesthesia given. (√) *Tick the option*	• Local only • Local and analgesia • General, no intubation • Any other (specify)
Time	……
Drug name	……
Dosage	……
Route	……

Signature of anaesthetist in case or regional or general anaesthesia

I. Surgical Approach (Strike out which ever is not applicable) Male Sterilization.

Local Anasthesia	Lignocaine 2%.....cc Other
Technique	Conventional……..NSV……
Types of incision Conventional/NSV	Single vertical…….Double vertical……..... Single puncture
Material for occlusion vas	2-0 Silk……..2-0 Catgut……..
Facial interposition	Yes……..No…… If no, give reasons…… …….. ..... .
Length of vas resected	…… .Cm
Suture of skin for conventional vasectomy	Silk……..Other……
Surgical notes	
Any other surgery done at time of sterilization?	Yes…….No…….. If yes, give details
Specify details of complications and management	

Name…….. Signature of the operating surgeon

Date……..

Female Sterilization

Local Anasthesia	Lignocaine……% Other
Timing of procedure. (√) *Tick the option used*	• Within 7 days post partum……. • Interval (42 days or more after delivery or abortion) • With abortion, induced or spontaneous • Less than 12 weeks…….. • More than 12 weeks…….. • Any other (specify)
Technique (√) *Tick the option*	• Minilap Tubectomy • With C section • With other survey…….

	• Laparoscopy Tubal Occulsion • SPL/DPL……..
Methods of occulasion of fallopian tubes. (√) *Tick the option used*	• Modified Pomeroy Laproscopy • Ring • Clip
Details of gas insufflations pneumoperitoneum created (CO_2/Air)	Yes…….No……..
Insufflator used	Yes…….No……..
Specify details of complications and management	

Name…… Signature of the operative surgeon

Date……..

J. Vital Signs: Monitoring Chart (For Female Sterilizations)

"*Sedation 0 – Alert 1 – Drowsy 2, - Sleeping/arousable 3 – Not Arousable*

Event	Time	Sedation	Pulse	Blood Pressure	Respiratory	Bleeding	Comments (Treatment)
Preoperative (Every 15 min after premedication							
Intra operative (continuous)							
Post Operative 1. Every 15 min for first hour and loger if the patient is not stable/awake 2. Every 1 hour until 4 hours	15min 30 min 45 min 1 hr 2hrs 3hrs						

after surgery	4 hrs						

Name ……..

Signature of the attending staffs

Date……..

K. Post-Operative Information

Passed time	Yes……..No……..
Abdominal distension	Yes……..No……..
Patient feeling well	Yes……..No……..
If no, please specify	Yes……..No……..

L. Instructions for discharge

Male sterilization client observed for half an hour after surgery	Yes……..No……..
Female sterilization client observed for four hours after surgery	Yes……..No……..
Post operative instructions given verbally	Yes……..No……..
Post Operative instructions given verbally	Yes……..No……..
Post operative instructions given in writing	Yes……..No……..
Patient counseled for postoperative instructions	Yes……..No……..
Comments	

Name…… Signature of the discharging doctor.

7. [C] IUCD

Source: Annexure 11 IUCD Reference Manual for Medical Officers,Ministry of H&FW,GOI

a) IUCD follow up card

IUCD (380 A) follow up card

Name of Centre _____ S. No._____

Name: Age (years):

Husband's name:

Address:

Contact no.(if any):

Obstetric status: LMP_____ LCB _____

Date of insertion:

S No. Date Remarks

Name/Signature of staff

1ST visit

2

3

4

5

6

7

8

9

10

Date of removal:

Reason for removal: desire for pregnancy/ pain/ bleeding/ others

b) IUCD Insertion Consent Form (may consider using insertion and removal consent forms)

c) IUCD Removal Consent Form

8. CONSENT FORM FOR IUCD INSERTION

I have requested and received information, in the language that I understand, on the Intrauterine Device (IUD) and have chosen to use this method of contraception. I have been counseled on the advantages and disadvantages of the IUD method. I also understand that the IUD does not protect me from HIV or any sexually transmitted infection and have been advised to use condoms to decrease the risk of infections. It is my responsibility to report any danger signs to my physician and come for follow up as advised.

Benefits/Advantages	**Risks/Disadvantages**
1. Very effective in preventing pregnancy 2. Easily reversible 3. Offers contraceptive "privacy" 4. Can be used by women who cannot use estrogen due to medical problems	1. May cause increase bleeding 2. May cause increase cramps 3. Must come for follow up as advised 4. Cannot be used by women at risk for pelvic infections 5. Offers no protection against HIV or STI i 6. Insertion may be uncomfortable

I hereby consent to the insertion of the _____ IUD and understand that it is effective until _____ at which time I must have it removed.

_____ _____ _____

Patient Signature Today's Date Professional Obtaining Consent

9.CONSENT FOR THE REMOVAL OF THE IUD

I have asked to have my IUD removed. I am aware that once the IUD is removed, I will need another method of contraception unless I am planning a pregnancy.

I have had an opportunity to discuss my questions and concerns and after doing so give my consent for the IUD removal.

_____ _____ _____

Patient Signature Date Doctor Obtaining Consent

10. IUCD Card (Sample)

Govt. Hospital
IUCD CARD
Name of the Facility Govt. Hospital ID/S. NO. .....

Client's Name ..... Husband's Name.....

Address.....Tel No.....

Age.....

Party.....

Date of Last Child birth/obortion.....

LMP.....

Date of Incretion..... Type of IUCD – Cu IUCD 380/Cu IUCD 375

Timing of incretion interval/Post-placental/Intra-caesarian/Postparturn (within 48 hours)

Provider: Gynae Specialist/Medical Officer/SR/Staff Nurse/LHV/ANM

Name of the Provider.....

Signature.....

Visits	Date	Purpose of Visit		Findings/Advice Given
		Routine	Complains (if any)	
1st Follow-up				
2nd Follow-up				
3rd Follow-up				
Additional Visit				

IUCD Removed on..... Reason for Removal .....

Alternative contraceptive provided: OCPs/Condoms/IUCD380A/IUCD375NSV/Tubectomy.....

Client ID/S No. .....

Name of the Facility .....

Name of the Client .....

Husband's Name .....

Age ..... Parity.....

Date of Incretion..... Type of IUCD – Cu IUCD 380/Cu IUCD 375

Timing of incretion interval/Post-placental/Intra-caesarian/Postparturn (within 48 hours)

Provider: Gynae Specialist/Medical Officer/SR/Staff Nurse/LHV/ANM

Name of the Provider.....

Signature.....

isites	Date	Purpose of Visit		Findings/Advice Given
		Routine	Complains (if any)	
1st Follow-up				
2nd Follow-up				
3rd Follow-up				
Additional Visit				

"Swasthya, Suraksha aur Aazadi; khushiyan Laaye IUCD''

How to Insert IUCD Safely

Screening and counseling of the client should be done as per GOI guidelines on IUCD.

Using gentle, 'no-touch' technique throughout, perform the following steps:

1. Prepare the client
   a. Give the woman a brief overview of the procedure
   b. Ask the client to urinate before the procedure
   c. Remind her to let you know if she feels pain
2. Check for instruments (ensure that all instruments are sterilized /disinfected)
3. Put a pair of new clean / high level disinfected gloves on both hands
4. Insert the high-level disinfected (or sterile) speculum and visualize the cervix
5. Cleanse the cervix and vagina with an appropriate antiseptic solution (Povidone Iodine or Chlorhexidine)
6. Gently grasp the cervix with the high-level disinfected (or sterile) volsellum and apply gentle traction
7. Carefully insert the high-level disinfected (or sterile) uterine sound
8. Gently advance the sound into the uterine cavity, and STOP when a slight resistance is felt
9. Note the angle of the uterine cavity, gently remove the sound and determine the length of the uterus
10. Carefully insert the loaded IUCD
11. Gently advance the loaded IUCD into the uterine cavity and STOP when the blue length-gauge comes in contact with the cervix or slight resistance is felt
12. After insertion cut the thread
13. Gently remove the volsellum and put it in 0.5% chlorine solution for decontamination
14. Examine the woman's cervix for bleeding
15. Gently remove the speculum and put it in 0.5% chlorine solution for decontamination
16. Allow the woman to rest
17. Counsel the client about
    a. Follow-up
    b. Side-effects and complications.

Note : The technique for post partum IUCD insertion is different.

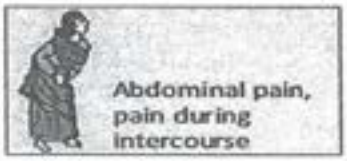
Who should not use IUCD:

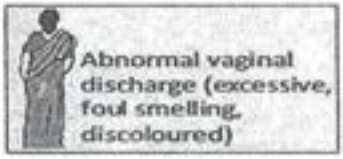
- Women who are pregnant
- Women who have purulent vaginal discharge (having Chlamydia and Gonorrhea infection)
- Women who have had STI or pelvic inflammatory disease in the last three months (IUCD can be inserted after treatment unless re-infection is likely)
- Women who have any kind of cancer in the female organs
- Women who have unexplained vaginal bleeding that is not part of their normal period

Return immediately to the hospital if any of the symptoms appear:

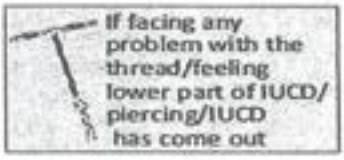

Late or missed periods (Possible pregnancy)


Abnormal spotting or bleeding


Abdominal pain, pain during intercourse


Abnormal vaginal discharge (excessive, foul smelling, discoloured)


Not feeling well, fever, chill


If facing any problem with the thread/feeling lower part of IUCD/ piercing/IUCD has come out

दिल्ली सरकार

आप की सरकार

Department of Health & Family Welfare, GNCTD