SOP

LaQshya Standard
Operating Procedures
for District Hospitals

Ministry of Health and Family Welfare
Maternal Health Division
2018

PROGRAMME OFFICER'S MESSAGE

The primary aim of LaQshya programme is to improve quality of care around birth and reduce maternal mortality and morbidity, neonatal mortality and still births. The interventions targeted specifically for labour rooms (LR) and maternity operation theatres (OT) under the programme, focus on strengthening of LR and OT.

In order to standardize and streamline our efforts to strengthen the LR and OT particularly of the District Hospitals, *LaQshya Standard Operating Procedures for District Hospitals* has been prepared. The SOP seeks to inform and assist health personnel at the district hospitals in providing safe intra partum services to pregnant women.

Child birth is a complex process, and it is essential to provide everything that is needed to ensure both the mother and new born child receive the safest care possible. The Standard Operating Procedures (SOP) and Checklists provided in this document are useful tools to organize such complex, and important processes and help deliver better and safer care in a variety of settings.

The SOP describes steps that the health personnel should follow in the labour rooms, OT, Central Sterile Supply Department. The SOP also describes at length the points to be considered to ensure respectful maternity care is provided at all levels to the pregnant women at the district hospitals.

Although the focus is largely on clinical procedures like pre-operative mechanisms, intrapartum procedures, etc., the SOP gives equal importance to the methods and procedures for ensuring respectful maternity care.

The WHO Safe Childbirth Checklist included in this document is an organized list of evidence-based essential birth practices and targets the major causes of maternal deaths, intrapartum-related stillbirths and neonatal deaths it would complement the SOP and ensure that quality care is provided to women giving birth at the health facilities.

Since the intrapartum processes are complex and dynamic, the users of the SOPs are encouraged to share the lessons learned during the application of the procedures for possible incorporation into future revisions of the document. While the SOP reflects usual practice, there will be circumstances from time to time that may require an adaptive response based on the professional judgement of the health personnel and decision makers.

Lastly, the technical contribution made by Dr. Archana Verma, General Manager, Quality Assurance Division, NHM, Uttar Pradesh and her team in forming up this document is huge and is duly acknowledged by the Maternal Health Division.

It is anticipated that the States and UTs find the *LaQshya Standard Operating Procedures for District Hospitals* valuable in strengthening services at the district hospitals and in providing safe and quality maternity care.

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SOPs: LABOUR ROOM

OBJECTIVES

- Improve Quality of care during the delivery and immediate post-partum period.
- Effectively manage obstetric and neonatal complications & high-risk pregnancies.
- Provide Respectful Maternity Care (RMC) to all pregnant women coming to the facility.
- Stabilization of complications and ensure timely and referrals to an appropriate facility and enable an effective two way follow-up system.
- Enhance satisfaction of beneficiaries visiting the health facilities.
- Ensure 100% compliance to administration of Oxytocin after birth & use of real time partograph during delivery.
- Ensure 100% compliance to infection prevention practices.
- Ensure zero stock out of necessary drugs and consumables.

Purpose:

To develop a system for ensuring care of pregnant women from antenatal to postnatal period and also address the needs of the new born. It includes a comprehensive approach to reduce maternal, neonatal, infant and less than 5 mortality and protect them from likely health risks they may face.

Scope:

It covers pregnant woman during the period, from day of her registration for first ANC to 42 days post-delivery & care of newborn. This includes the referral services as well.

Responsibility:

In-charge of hospital, Service Provider in OBG Department, Paediatrician, Medical officer and staff nurse /ANM

Standard Procedures:

SOP for receiving and assessment of the patient of delivery, SOP for Intra partum care

S.NO.	ACTIVITY	RESPONSIBILITY	REFERENCE DOCUMENT / RECORD
1	Service Provision: All the maternal and Child Health Services are provided as per IPHS for District Hospitals and Operation Guidelines for Maternal & Child Health issued by MoHFW, Government of India. This Includes: • Antenatal Care including Management of High Risk Pregnancies referred form level 1 and institutions • 24X7 services for Emergency Obstetric Care & Newborn care • Emergency Care of Sick Newborn • Family Planning Services • Counselling	Facility-in-charge	IPHS for District Hospital
1.1	Labour Room preparation: • The Labour Room is prepared and kept ready before hand with all necessary equipment as per the Labour Room checklist. • Adequate privacy for the PW with curtains and visual blocks is ensured	Staff Nurse (primary)	
2	Communication with pregnant woman and her family: • PW and accompanying family members are greeted respectfully • It is ensured that no derogatory comments are made • LR procedure is explained to the PW and the attendant • Consent of the PW is taken before starting any physical and vaginal examination • Family planning services are offered to the PW	Staff Nurse (primary)	
2.1	Supportive care in Labour Room: • PW is encouraged to walk around and pass urine frequently • A relative is allowed to stay with the women as birth companion • PW is instructed to eat and drink frequently. She	Staff Nurse(primary)	

	is advised to take light food like-tea, milk, biscuits etc. and avoid heavy meals. • She is advised to adopt posture of her choice and do slow and deep breathing during contractions		
2.2	**Procedure for Admission / Shifting / Referral:** • The Pregnant women are admitted to the hospital either when they arrive in Labour or when they nearing the delivery. • Pregnant woman is diagnosed for high risk signs such as mal presentation, and indicated for elective C-Section surgery are admitted 2-3 days prior to expected date. • Pregnant Women, received in Casualty/ Emergency, are attended by EMO and are directed towards labour room if no immediate resuscitation/ intervention is required. • Pregnant women directly reaching labour room/LDR are received by Medical Officer / nursing staff on duty. • Medical officer /Staff nurse analyzes condition of the patient along with history and reviews old records, including referral slip, if available, to assess any complications associated with pregnancy. • If pregnant woman is in first stage of labour she is shifted to pre partum observation beds where vitals and dilation is monitored on periodic basis and partograph is established. • If pregnant woman is in active first stage of Labour she is shifted to labour room. • Pregnant woman with complication but stable is transferred to Obstetric HDU and unstable with complications is shifted to Obstetric ICU. • Pregnant woman requiring emergency C-Section is shifted to pre-operative ward of OT immediately after preparation. • Pregnant women in false labour / Observation are monitored and subsequently discharged. • When the condition of the patient is such that	Medical Officer/ Staff Nurse	

	she cannot be handled in the Facility due to the complications or due to lack of facilities, timely referral is done for the next higher appropriate facility with full record by ambulance services. • For every admitted pregnant woman bed head ticket is generated and entry is done in IPD register • Shifting of Patient to concerned Ward : o Patient is shifted to the concerned in-patient facilities accompanied by the patient attendant o Stretcher/wheel chair/Trolley are used for shifting of patient as required.		
2.3	**Procedure for requisition of diagnostic test and receiving of the reports:** • If any laboratory test is required to be done then the treating Doctor prescribes the test on the Lab/ X-ray/ USG requisition form. • In routine cases, Staff nurse collects the sample for HIV, Urine albumin and Hb. after identifying the patients with two identifiers, sample is sent to the laboratory with the requisition form. • In emergency cases where patient needs to be transferred to OT for emergency LSCS, laboratory technician (in-house /outsourced) is informed by the staff nurse. Lab technician comes to the ward and collects the sample. Rapid test kits are another alternative for emergency tests. • A separate Lab registration number is generated and given to the patient's attendant for collection of report. • Report is received within the defined Turn Around Time from the Lab. • In routine cases, if X-Ray, ECG or USG needs to be done, nurse informs the concerned technician, and at appointed date & time the patient is transferred to the concerned department for the investigation. • Report is received within the defined Turn		Checklist for Labour room preparedness

	Around Time from the Radiology (X-ray / USG) department.		
2.4	**Arrangement of intervention for Labour room:** • The Nurse-in-charge maintains inventory for the necessary equipment, drugs & consumables and other facilities required for the delivery. • The Nurse-in-charge timely indents after scientific calculation of consumption of necessary drugs and consumables. The Nurse-in-charge maintains buffer stock of necessary drugs & consumables. Functionality of required equipment and Availability of Drugs &consumables is ensured and checked on daily basis. • Any breakdown of equipment or shortage of supply is intimated to Facility Administration and immediate corrective actions are taken. • AMC and annual calibration of critical equipment is done annually.	Nurse in-charge / CMS / Hospital Manager / Departmental Nodal Officer for Quality	
2.5	**Procedure for Blood Transfusion:** • Blood transfusion may be required in conditions like postpartum hemorrhage leading to shock and severe anemia. • Transfusion is prescribed only when the benefits to the woman are likely to outweigh the risks. • Functional linkage to 24x7 blood bank/ Blood storage Unit facility is available in hospital. • In emergency lifesaving conditions blood is issued without replacement after recommendation from treating doctor / authorized person. • Cross matching of donor and recipient blood is mandatory before transfusion. • For High Risk patients attendants are told to arrange blood in advance. • Blood transfusion is closely monitored by skilled staff • Corrective action for Blood Transfusion Reaction, if any, is taken.		

	• Blood Transfusion Reaction form is reported to concerned blood bank. Prior to requesting the transport of blood products, ensure: • The patient has an IV line established with saline • The physician orders for transfusion have been documented • Informed consent has been obtained. • Blood is received from Established Blood Banks only against a requisition form along with the sample for grouping& cross-matching, duly signed by the medical staff • Staff nurse/ Ward Attendant) collects blood components from blood storage, transports blood component in insulated container to location and delivers it to nurse in charge • Inspect for abnormal color, cloudiness, clots and excess air. • Check with compatibility slip to ensure that the following information on the unit of blood is the same as that on the Blood compatibility: o Blood unit number of Collection date o Expiry date o ABO blood group and Rh group o Patients name matching with the requisition slip/case file o Number of units supplied • It is ensured that blood is stored in monitored refrigerators designated for the purpose which can maintain the temperature at 2 - 6 degrees celsius. • It is ensured that blood components are NOT kept at room temperature or in an unmonitored refrigerator. • If whole blood or packed red cells infusion is not started within 30 minutes of issue from the blood bank the unit is placed in a monitored refrigerator.		

- Thawed FFP is also placed in a monitored refrigerator and is stored only up to 24 hours after thawing; best infused before 6 hours after thawing

- Platelets are stored in a platelet incubator at 20–24 degrees celsius with constant agitation and are taken from the blood bank only at the time of infusion.

- Aseptic technique and Universal Blood and body Substance Precautions are followed throughout; hand washing is in accordance with the policy.

- Each unit of blood is checked at the bedside by two nurses or a nurse and a doctor, and documented.

- Rate of transfusion is followed as mentioned below:

    - For Adults: Start with 1 ml/min for first 15 minutes. If no reaction, increase to 4ml/minutes after 15 minutes.
    - For Pediatric Transfusion: Advice is taken from Treating Paediatrician

- If patient shows evidence of a transfusion reaction the transfusion is immediately discontinued at cannula hub, infusion of 0.9% Sodium Chloride is started and the concerned physician responsible for the case/on duty is informed.

- The transfusion reaction form duly completed is returned to the blood bank along with samples for investigations as instructed on the reaction form.

- If no evidence or reaction and vital signs are stable after 15 minutes, the flow is adjusted to prescribed rate.

- Vital signs are assessed one hour after transfusion and as necessary thereafter;

- The patient is continuously assessed for delayed transfusion reactions.

- No medications or solutions are added to or

	infused through the same tubing as blood components, except 0.9% Sodium Chloride • The administration set is only used for up to four hours from the time of starting the infusion of red cells. • Duration of a blood transfusion is not normally exceeding four hours per unit of blood. • Blood & Blood Bags are discarded as per BMW policies. Compliance requirements: Intake and Output sheet documents: ○ Amount of blood transfused ○ Blood unit and number ○ Start and finish time of transfusion ○ Amount of saline infused • Nurses document the patient's response to the transfusion.		
	History taking and examination of woman in Labour		
3.1	**History of patient is taken:** • Time of onset of contraction • Frequency of pains, • Leaking/bleeding PV, • Baby movements) • Initiate safe birth checklist to manage and make appropriate referral • Physical examination is done to check following parameters (Pulse, temperature, BP, pallor) • Abdominal examination is done to check following parameters (Fundal height, Fetal lie & presentation, Fetal heart rate (FHR), Frequency, duration and intensity of contraction) Per vaginal examination is performed: • Strict asepsis (hand hygiene, sterile gloves and cleaning of vulva using antiseptic) is followed • Cervical dilatation and effacement are determine • Status of presentation and membranes is seen • Color of liquor is noted if membrane is already		

	ruptured • Station of the presenting part is checked • Determine adequacy of pelvis for a normal Labour. • Signs of true Labour are looked for : Painful contractions, Blood-stained mucus discharge from vagina (—show) • Formation of bag of water.		
	Procedure for Emergency Obstetric Care		
3.2	Identification of complications and referrals: • Cephalo Pelvic Disproportion (CPD), • Heavy bleeding per vaginum: If one pad getsoaked every minutes) • Shock (fast and feeble pulse, systolic BP less than 90 mm Hg, cold and moist skin) • Convulsion • Dangerous fever (temperature more than 38C) • Respiratory difficulty • Fetal distress- FHR less than 120/minute or more than 160/minute, meconium stained liquor • Transverse lie, breech presentation • Previous caesarean section • Labour more than 24 h • Preterm Labour (34wk or lesser) • Multiple births • Pregnancy Induced Hypertension (PH) • She is RH(-ve) • Prolapsed cord • **Bleeding PV**: no vaginal examination. Insert IV cannula, give IV fluids (normal saline or ringer lactate solution) • **Shock**: left lateral position with legs higher up than chest, give oxygen, insert IV cannula, give IV fluids (normal saline or ringer lactate solution) • **Convulsions**: Place the patient inleft lateral position, clear airway, protect from injury and give oxygen. Treat the woman with magnesium Sulphate. ○ Pre referral:Loading dose in L1 and L2. Facilities is 10 gms IM (50%) (5 gmsin each buttock)in the presence of Medical Officer. ○ Loading dose–total dose 14 gms- 4 gm IV (20%) + 10 gm IM (50%)(5 gm in each buttock) in presence of MO in L3 Facilities	Medical Officer / Staff Nurse (primary)	

	○ Maintenance Dose: 5gm IM 4 hourly for 24 hours either from the last convulsion or delivery (whichever comes first) ○ Additional dose to be given if convulsion occurs within 2 hours- 2 gm IV (20%) • **High Grade fever**: Insert an IV fluids (dextrose saline, normal saline or ringer lactate solution) and treat as advised • **Respiratory difficulty or Cyanosis**: check airway, suction to remove secretions if present and give oxygen • **Foetal Distress**: Put the mother in left lateral position, give IVfluids and oxygen • **Preterm Labour (34 wk or lesser):** initiate antennal corticosteroids therapy: injection dexamethasone 6 mg IM start (and every 12 hourly, for a total of 4 doses) • **Prolapse cord:** Raise the buttocks higher than the shoulders. With the help of pillow or folded sheet under the buttock, the presenting part should be kept pushed up by inserting gloved hand in the vagina. Consider delivering in the PHC only if the woman is in advanced Labour . Expedite the delivery. Be prepared for resuscitation of the newborn as per the Section 1.7).		
	Trays to be kept in Labour room		
	1. **Delivery tray**: Gloves, scissor, artery forceps, sponge holding forceps, urinary catheter, bowl for antiseptic lotion, gauze pieces and cotton swabs, speculum, sanitary pads, Kidney tray. 2. **Episiotomy tray**: Inj. Xylocaine 2%, 10 ml disposable syringe with needle, episiotomy scissor, kidney tray, artery forceps, Allis forceps, sponge holding forceps, toothed forceps, needle holder, needle (round body and cutting), chromic catgut no. 1, gauze pieces, cotton swabs, antiseptic lotion, thumb forceps, gloves. 3. **Baby tray**: Two pre-warmed towels/sheets for wrapping the baby, cotton swabs, mucus extractor, bag & mask, sterilized thread for cord/cord clamp, Nasogastric Tube and gloves		

	Inj. Vitamin K, needle of gauze 26 and syringe 1ml. (Baby should be received in a Pre-warmed towel. Do not use metallic tray.) 4. **Medicine tray**: Inj. Oxytocin (to be kept in fridge), Cap Ampicillin 500 mg, Tab Metronidazole 400 mg, Tab Paracetamol, Tab Ibuprofen, Tab B complex, IV fluids, Tab. Misoprostol 200 micrograms, Inj. Gentamycin, Vit K, Inj. Betamethasone, Ringer lactate, Normal Saline, Inj. Hydrazaline, Tab. Nifedepin, Tab. Methyldopa, inj. Labatolol, Inj. Dexamethasone and magnifying glass. (Note: Nevirapin and other HIV drugs only for ICTC and ART Centers) 5. **Emergency drug tray**: Inj. Oxytocin (to be kept in fridge), Inj. Magsulf 50%, Inj. Calcium gluconate-10%, Inj. Dexamethasone, Inj. Ampicillin, Inj. Gentamicin, Inj. Metronidazole, Inj. Lignocaine-2%, Inj. Adrenaline, Inj.HydrocortisoneSuccinate, Inj. Diazepam, Inj. Pheneraminemaleate , Inj. Carboprost, Inj. Fortwin, Inj. Phenergan, Ringer lactate, normal saline, Betamexthazon, Inj. Hydrazaline, Nefidepin, Methyldopa, IV sets with 16-gauge needle at least two, controlled suction catheter, mouth gag, IV Cannula, vials for Drug collection. Ceftriaxone (3rd generation cephalosporins) - For L3 facility. (Note: Only for L2, L3 facilities) 6. **MVA/ EVA tray**: Gloves, speculum, anterior vaginal wall retractor, posterior vaginal wall retractor, sponge holding forceps, MVA syringe and cannulas, MTP cannula, small bowl of antiseptic lotion, sanitary pads, pads / cotton swabs, disposable syringe and needle, misoprostol tablet, sterilized gauze/pads, urinary catheter. 7. **PPIUCD tray:** PPIUCD Insertion Forceps, Cu IUCD 380A/ Cu IUCD 375 in a Sterile package. Sim's speculum, Ring forceps or sponge holding forceps, , Cotton swabs, Betadiene solution (Note: Only for facilities with PPIUCD trained		

	SOP: INTRAPARTUM CARE		
S.NO.	ACTIVITY	RESPONSIBILTY	REFERENCE DOCUMENT / RECORD
4	Identification of stage of labour: • 1st stage (latent phase): cervical dilatation: 0-3 cm; weak and infrequent contractions • 1st stage (active phase): cervical dilatation 4 cm or more, strong and frequent contractions • 2nd stage: cervix fully dilated till delivery of baby • 3rd stage: after delivery of baby until delivery of placenta	Staff Nurse (Primary)	
	Care during labour		
5.1	1st stage: • Monitoring is done every 1 hour ○ BP, temperature and pulse, ○ Uterine contractions and fetal heart rate • PV examination every 4 hours ○ Cervical dilatation, effacement, status of membranes, station of head, colour of liquid if membrane ruptured. ○ Unless indicated vaginal examination is not performed more frequently than once every 4 hours. • If any complication is seen as in Section 3.2 the medical officer is called in for further management. • Refer to appropriate higher facility if no progress in cervical dilatation in 8 hours despite strong and frequent uterine contraction. • If after 8 hours contraction subsides and there is no progress of cervical dilatation-it is probably false Labour and woman is discharged. She is advised to keep a fetal movement count (10 movements in 12 hours) and return if labour pains recur or there is bleeding or leaking per vaginum	Medical officer/ Staff Nurse (Primary)	
5.2	1st Stage: Pregnant woman is not left alone Following signs are monitored every 30 minutes:	Medical officer/ Staff Nurse (Primary)	

- Frequency of contraction
- FHR (Foetal Heart Rate)
- If membranes ruptured, colour of liquid is noted
- For any complications as in Section 3.2

PW is monitored every 4 hours for:

- Pulse, BP
- PV examination is done and following observations are looked for:
  - Cervical dilatation and effacement, status of membrane and colour of liquid
  - Descent of presenting part

Partograph is plotted- when the woman reaches active labour.

The following points are noted:

- Fetal condition: Fetal heart rates are counted every half hour. Count the FHR for one full minute. The rate is counted immediately following a uterine contraction. If the FHR is >160/minute or <120/minute, it indicates fetal distress. It is managed as mentioned in Section 3.2

  Woman is observed every 30 minutes for any leaking PV. If present, the color of the amniotic fluid is noted as visible at the vulva, recorded as:
  - Clear (mark .C.)
  - Meconium stained (mark .M.)
  - No liquor (mark .A.)

Labour- Plotting is done on the partograph once the woman is in active labour.

- Active labour is present if cervical dilatation is 4 cm or more with at least 3 good uterine contractions (i.e. each lasting for more than 30-40 seconds) per 10 minutes.
- Cervical dilatation is recorded in cm in the beginning and every 4 hourly
- Every half hour the number of good contractions (lasting over 30-40 seconds) in 10 minutes are recorded, and appropriate boxes are blackened
- Initial recordings are placed to the left of the Alert Line and normally the line should continue to remain to the left of the Alert Line. Write the time accordingly in the row for time.
- If the Alert Line is crossed (the graph moves to the right of the Alert Line) it indicates a prolonged labour. The time is noted when the Alert Line is crossed. Medical officer is called to

	reassess/monitor. The woman is encouraged to empty the bladder. The woman is reassessed in 2 hours if no progress, the obstetrician is called in for further management. Crossing of the Action line (the graph moves to the right of the action line) the obstetrician is called in for further management. • Intervention: Any drug administered during labour, is mentioned in the record including the time dose and route of administration. • Maternal Condition: Maternal pulse and BP are recorded every half hour and plotted on the partograph. Both systolic and diastolic BP are recorded using a vertical arrow.		
5.3	**2nd Stage: Delivery of the baby:** Findings are record regularly in labour record and partograph Following signs are monitored every 5 minutes: • Frequency, duration and intensity of contraction • FHR • Perineal thinning and bulging • Visible descent of the foetal head during contraction • Any complications as in Section 3.2 **Delivering the baby** • It is ensured that the newborn care corner is prepared and equipment for neonatal resuscitation are ready • It is ensured that the bladder is empty • The woman is encouraged to push if she has the urge to do so during contractions and relax in between. • Bearing down effort is not required until the head has descended into the perineum. Thus no active pushing is allowed • Controlled delivery of head is ensured by taking the following precautions: The perineum is supported with the left hand during delivery and the anus is covered with a pad held in position by the side of the left hand and right hand is used to maintain the slight flexion of the head • Once head is delivered, assistance in delivery of	Medical officer/ Staff Nurse (Primary)	As per standard treatment guidelines

	the shoulders and the rest of the baby is provided ○ Spontaneous rotation and delivery of the shoulders is waited for ○ Gentle downward pressure is applied to deliver the top (anterior) shoulder ○ The baby is lifted up towards PW's abdomen, to deliver lower (posterior) shoulder ○ The baby is placed on PW's abdomen in skin to skin contact (even before cutting the cord) ○ The time of birth is noted ○ The baby is dried immediately. The scrubbing of the vernix is avoided. ○ Baby's breathing is assessed while drying: If baby is breathing well, no further action is taken. The clamping of the cord is delayed. ○ If the baby is not breathing or he/she is gasping: Clamp and cut the cord and shift the baby to radiant warmer for resuscitation • 10 IU oxytocin is given IM to the PW within 1 min of the delivery of the baby. If heavy bleeding 10 IU Oxytocin IM is repeated in 10 minutes • Baby is placed on the PW's abdomen for skin-skin contact • Clamping and cutting of the cord: ○ If the baby is crying: the clamping of cord is delayed and the cord is tied and cut between 1-3 minutes ○ Clamps are put on the cord at 2 cm and 5 cm from the baby's abdomen ○ Cord is cut between the ties with a sterile blade. ○ Oozing of blood from the stump is looked for. If there is oozing, a second tie is placed between the baby's skin and the first tie. • Initiation of breast feeding is encouraged and ensured Immediately after birth or within an hour Precautions/ Emergency signs: • If the woman has tight perineum, which may interfere with delivery, episiotomy is given and the delivery of head is controlled carefully. Routine episiotomy is not performed without indication			

	• Stuck shoulder (shoulder dystocia) Medical officer/Obstetrician (who is readily available)is called for the help. Liberal episiotomy is done. • The assistant is asked to apply supra-pubic pressure and the person who is conducting delivery applies gentle downward traction on the fetal head. If unsuccessful, patient is referred urgently to higher facility.		
5.4	3rd stage- Delivery of the placenta: Signs of placental separation are looked for and placenta is officer/Staff delivered by controlled cord traction • Signs of placental separation: Lengthening of the cord, fresh gush of blood, supra-pubic bulge, and placenta lying in the vagina • Delivery of the placenta: Left hand is placed over pubic symphysis and the fundus of uterus is pushed up. Right hand is used to apply controlled downward traction on the cord to pull the placenta out. • If placenta does not descend, both cord traction and counter traction are released on the abdomen until uterus contracts again and then the above step is repeated After delivery of the placenta: It is checked if the uterus is well contracted and there is no heavy bleeding. Examination is repeated every 15 minutes for first hour. • If uterus is relaxed and there is heavy bleeding, the uterus is massaged and 10 IU oxytocin IM is given stat. 10 IU of oxytocin infusion (in 500 cc ringer lactate) is started at 60 drops per minute. Bladder is emptied. • If bleeding persists and uterus is soft, continued massaging of uterus is done and bimanual compression is applied. • IV fluids with 10 IU oxytocin are continued at 30 drops per minute, if bleeding gets controlled. Check the perineum, cervix and vagina for tears. Repair if needed. Blood loss is estimated and recorded throughout third stage and immediately afterwards. If blood loss equals to or more than 500 ml management of PPH is to be done as per standard guidelines. Intensive monitoring is done (every 30 minutes) for 4 hours for	Medical officer/ Staff Nurse (Primary)	

	• BP, Pulse • Respiratory rate • Uterine contraction to make sure it is well contracted • Vaginal bleeding The woman is assisted when she first walks after recovering PW and baby are kept in delivery room for a minimum of one hour after delivery of placenta The placenta is disposed as per biomedical waste management rules, 2016. The obstetrician is called in for further management if: • Unable to remove placenta by 1 hour after delivery or if blood loss is more than 350 ml and bleeding still continues (more than 3 pads soaked in 5 minutes the uterus is massaged until hard, oxytocin infusion @ 40- 60 drops /min is continued and pulse and BP are checked every 15 minutes. If baby is still born, Supportive care is given. • The parents are informed as soon as possible • The possible causes of death are discussed with PW and her family • Body is handed over to relatives • The record is maintained in death register		
	Care After Delivery		
6	**Care of PW and newborn after delivery:** • Findings, treatment and procedures are recorded in the patient's labour record • PW and baby are kept under observation in delivery room. They are not separated. • The PW and the newborn are not left alone • Breast feeding is ensured within first hour	Staff Nurse(Primary	
6.1	**Care of PW:** • Watch for vitals, urine output, bleeding per vaginum and uterine tone • Assessment is done every 30 minutes for next 2 hours, then every 6 hours up to 48 hours.	Medical Officer/Staff Nurse (Primary	

	• The woman is encouraged to pass urine • In case of excessive bleeding, the management of PPH is done as per standard guidelines • PW is encouraged to eat and drink, and rest • Birth companion is asked to stay with the PW and newborn. • PW and newborn are not to be left alone. The companion is instructed to call for staff nurse in case the PW has the following danger signs like: ○ Feels dizzy ○ Severe headache, visual disturbance ○ Pain in the abdomen ○ Increased pain in the perineum ○ Excessive bleeding • If unable to manage, MO is called for further Management		
6.2	Care of the newborn: • The baby is dried. Vernix is not removed and the baby is not given a bath. • The PW and baby are allowed to remain together for skin-to-skin contact. Both of them are covered with a blanket. • The PW is encouraged and supported to continue breast-feeding. The newborn is not given anything other than own PW's milk. • The weight of newborn is measured, if birth weight<1800g then the baby is immediately referred to SNCU / higher facility. • The baby is assessed every 30 minutes till 2 hours for: Any emergency signs (PW and / or companion also to be explained) like: ○ Lethargy or cyanosis ○ Pallor ○ Difficulty in breathing ○ Grunting ○ Fast breathing (>60/min) ○ Chest in-drawing ○ Convulsions ○ Body temperature ○ Bleeding from the umbilical cord. • Breast-feeding is assessed to see if the baby is	Staff Nurse (Primary)	

	able to attach correctly and is positioned well and to check if the baby is sucking effectively • The Pediatrician/Obstetrician is called in case of any complication • If treatment is not possible at the facility, then the baby is referred to the higher facility immediately.		
	Neonatal Resuscitation		
7	• Resuscitation is started immediately if the baby is not breathing or gasping • Neonatal resuscitation is discontinued if there is no sign of life after 10 minutes of resuscitation. Prognosis of newborn is discussed with parents before discontinuing resuscitation. • Paediatrician & SNCU in charge is intimated for the further management. ○ The baby is kept warm ○ The cord is clamped and cut ○ The baby is transferred to a dry, clean and warm surface like under a radiant heater ○ The head is positioned in slight extension and turn the head to over side ○ The airway is opened ○ First the suction of mouth is done and then the nose if required ▪ The suction tube is introduced into the newborn's mouth 5-cm from lips and suck while withdrawing ▪ The suction tube is introduced 3-cm into each nostril and suck while withdrawing until no mucus ▪ Each suction is repeated if necessary ○ Tactile stimulation is given ○ Reposition ○ If still no / irregular breathing and HR > 100/ minute start ventilation ▪ Mask is placed to cover the chin, mouth and nose and form a seal ▪ Ambu bag is squeezed and rising of chest is observed ▪ If breathing or crying with more than 30 breaths per minute and no severe chest in-drawing, ventilation is stopped.	MO/ Paediatrician/ Staff Nurse	

	▪ Evaluate after 30 sec, if HR increasing continue PPV. If HR <60 per minute, start chest compressions in ratio of 3 chest compressions to one breath per minute ▪ Discontinue when HR increases to more than 60 per minute and breathing stabilizes. ▪ In case of deterioration inspite of PPV, call for additional help from medical expert for further resuscitation. ▪ Baby is kept under observation in Radiant Warmer when baby is stabilized (HR > 100 bpm & breathing well) then kept in skin-skin contact with PW's chest Baby is monitored every 15 minutes for breathing and warmth ▪ If breathing is less than 30 breaths per minute or severe chest in drawing, ventilation is continued Immediate referral to District Hospital is arranged. If no breathing at all after 20 minutes of ventilation ▪ Ventilation is stopped. The baby is declared dead PW is explained and supportive care is given to her. ▪ The event is recorded.		
	Management of High risk Pregnancy		
8.1	**High Risk Pregnancy cases are patients who have associated problems with Pregnancy such as:** 1. Grand multipara 2. Previous 3rd stage abnormalities / problems 3. All major Medical Disorders 4. Multiple Pregnancy 5. All malpresentations 6. BOH 7. CPD 8. APH 9. Previous LSCS 10. PIH/ Eclampsia, Gestational Diabetes 11. Recurrent premature labour 12. Rh negative women with Rh positive husband 13. Gynaecological abnormality 14. Elderly primi 15. History of Infertility 16. Gross obesity	Medical Officer/ Gynaecologist/ Nurse In-charge	Simplified Partograph

	17. Oligo/Polyhydramnios 18. Extremes of age regardless of parity, < 18 yrs / > 35 yrs. Both are in need of attention, medical or social, due to various problems. **Management of 1st stage of labour in High Risk Pregnancy:** • The patient is informed about the condition, counselling is done and consent is taken by the nurse in-charge and medical officer. • A partograph is established by staff nurse. • Monitoring & charting of uterine contraction, Foetal heart rate, emergency signs, cervical dilation, BP, temperature and Pulse is done on periodic basis depending upon low/ high risk pregnancy and progress is updated in partograph. • In any condition of unsatisfactory progress of labour due to prolonged latent phase, non progress of labour, prolonged active phase, foetal distress, cephalopelvic disproportion, obstruction, mal-presentation, mal-position, prolonged expulsive phase, the obstetrician is called in for further management. • Decision about induction or augmentation of labour, vacuum extraction, forceps delivery, Craniotomy or C-Section after careful assessment of patient and procedure is performed as per standard EmOC guidelines. • Paediatrician & Anaesthetist is alerted of anticipated surgery and newborn complications. • OT In charge is also alerted for preparedness of Operation Theatre in case surgery is required.		

8.2	**Management of 2nd stage of labour in High Risk Pregnancy:** Uterine contraction, FHR, Perineal thinning & Bulging, visible descent of foetal head during contraction and presence of any sign of emergency is monitored periodic basis depending upon the low or high pregnancy. Paediatrician on call is informed about the imminent delivery in advance and as soon as patient is shifted to second stage of labour/operation theatre (All deliveries are attended by Paediatrician on call). Episiotomy is performed if required. In case of shoulder dystocia, obstetrician is called in for further management. Delivery of baby and time of delivery is noted. Cord is tied and cut with a sterile blade after 2-3 minutes of delivery. Immediate newborn care is given. If newborn cries in 30 seconds newborn resuscitation is started.	Nurse in-charge	Guideline for pregnancy care and management
8.3	**Management of 3rd stage of labour in High Risk Pregnancy:** Inj. Oxytocin within one minute of delivery is administered. Controlled cord traction is done for assist expulsion of placenta. Uterine massage is given to prevent PPH If there is retained placenta or PPH it is managed as per standard protocol. BP, Pulse, Temperature, vaginal bleeding is monitored periodically for three hours. In case the child delivered is dead, then the body is handed over to relatives and record is maintained in death register as still birth.	Nurse charge/ Medical Officer/ Gynaecologist.	Labour Register/ Birth register/ Death register. WI for Active Management of 3rd Stage of Pregnancy. WI for PPH
8.4	**Immediate Postpartum Care:** Assessment is done for contraction of uterus, vaginal/	MO/ Obstetrician/	Guideline for pregnancy

	perineal tear. Sanitary Pad is placed under the buttock to bleeding and for collecting the blood Assessment of blood loss is done by counting the blood soak pads. Vitals are monitored at periodic intervals. PW and newborn are kept together. Breast-feeding is encouraged. Birth Companion is asked to stay with the PW. She was instructed to call for help in case of any danger sign. Weight of newborn is measured. Information of PW and newborn is recorded in labour register Newborn and PW is given identification tags.	Staff Nurse/ Labour Room Companion/ MAMTA	care and management of obstetrics complications for MO/ Labour Room Register
8.5	**Essential Care of New Born:** Essential new born care is given including maintain body temperature, maintaining airway &breathing, breast feeding of new born, care of cord and eyes.	Staff Nurse	WI for Immediate Newborn Care WI for Preventing Hypothermia
	C-section		
9	**C-Section Surgery:** 24X7 availability of obstetrician or Medical Officer Trained in EmOC is ensured. Non-availability of obstetrician for procedure is immediately informed to Hospital Superintendent/ Hospital Manager so alternative arrangement or referral to higher facility can be made.	Obstetrician/ Hospital Superintendent /Hospital Manager	
9.1	**Preparing Women for Surgical Procedure:** Procedure to be performed woman. If the woman is unconscious, it is explained to her family. Informed consent for the procedure is obtained from the women /relatives. Woman's medical history is reviewed and checked for any possible allergies. Blood sample is sent for haemoglobin or haematocrit and type and screen. Blood is ordered for if there is possibility of transfusion.		

	Area around the proposed incision site is washed with soap and water, if necessary. Woman's pubic hair is not shaved as this increases the risk of wound infection. The hair may be trimmed, if necessary. Vital signs are monitored and recorded. (Blood respiratory rate and temperature). WHO Safe Surgical Checklist is being used Premedication appropriate for the anaesthesia is administered. Antacid is given to reduce stomach acid in case there is aspiration. Bladder if catheterized if necessary and urine output is monitored. Relevant information is passed on to other members of the team (doctor/midwife, nurse, anaesthetist, assistant and others) is pregnancy, pulse ensured.		
10	**Criteria to distinguish between Newborn death and Still birth:** Live birth is the complete expulsion or extraction from its PW of a product of conception, irrespective of the duration of the pregnancy, which, after such separation, breathes or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered liveborn. **Stillbirth** is fetal loss death prior to the complete expulsion or extraction from its PW of a product of conception, irrespective of the duration of pregnancy; the death is indicated by the fact that after such separation the foetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles. **The perinatal period** commences at 22 completed weeks (154days) of gestation and ends on 7th completed days after birth.		

The **neonatal period** begins with birth and ends on 28 days after birth. Neonatal deaths may be subdivided into early neonatal deaths, occurring during the first seven days of life (0-6 days), and late neonatal deaths, occurring after the seventh day but before the 28th day of life (7-27 days).

A decrease or cessation in sensations of fetal activity may be an indication of fetal distress or death, though it is not entirely uncommon for a healthy foetus to exhibit such changes, particularly near the end of a pregnancy when there is considerably less space in the uterus than earlier in pregnancy for the foetus to move about.

Still, medical examination, including a non-stress test, is recommended in the event of any type of any change in the strength or frequency of fetal movement, especially a complete cease; most midwives and obstetricians recommend the use of a kick chart to assist in detecting any changes.

Foetal distress or death can be confirmed or ruled out via foetoscopy / doptone, ultrasound, and/or electronic fetal monitoring. If the foetus is alive but inactive, extra attention will be given to the placenta and umbilical cord during ultrasound examination to ensure that there is no compromise of oxygen and nutrient delivery.

The World Health Organization recommends that any baby born without signs of life at greater than or equal to 28 completed weeks' gestation be classified as a stillbirth.

Causes of still birth:

- Problems with the placenta, which nourishes the baby, can lead to a stillbirth in around two thirds of cases. In a placental abruption, the placenta separates too soon from the uterine wall.

Other causes of stillbirth include:

- Umbilical cord problems also cause stillbirths. In a prolapsed umbilical cord, the cord comes out of the vagina before the baby, blocking the oxygen supply before the baby can breathe on its own.

- A PW's medical condition that existed before or developed during the pregnancy can lead to stillbirth. Women are at increased risk if they have type 1 diabetes or untreated diabetes before or during pregnancy. High blood pressure - particularly pregnancy -induced high blood

	pressure or pre- eclampsia - is another major cause of stillbirth. • Sometimes the foetus may grow too slowly. This condition, called intrauterine growth restriction (IUGR), puts the foetus at risk of dying from lack of nutrition. **Conditions Associated with Stillbirth:** Infection • Severe maternal illness • Placental infection leading to hypoxemia • Fetal infection leading to congenital deformity • Fetal infection leading damage of a vital organ • Precipitating preterm labour with the fetus dying in labour Maternal medical conditions • Hypertensive disorders • Diabetes mellitus • Thyroid disease • Renal disease • Liver disease • Connective tissue disease (systemic lupus erythematosus) • Cholestasis • Antiphospholipid syndrome • Heritable thrombophilias • Red cell alloimmunization • Platelet alloimmunization • Congenital anomaly and malformations • Chromosomal abnormalities including confined placental mosaicism • Fetomaternal hemorrhage • Fetal growth restriction • Placental abnormalities including vasa previa and placental abruption • Umbilical cord pathology including velamentous insertion, prolapse, occlusion and entanglement • Multifoetal gestation including twin–twin transfusion syndrome and twin reverse arterial perfusion • Amniotic band sequence • Central nervous system lesions		
	Inpatient Care		
11.1	**Post Natal Inpatient Care of PWs:** After delivery, PW is shifted to the labour ward for post-	Staff Nurse	SOP for IPD Management

	natal care Maternal health is monitored and every step shall be taken to improve well-being and good health of PW & new born Medication is administered when required and prescribed by the doctor. The patient is encouraged for taking normal diet, plenty of fluids, IFA and Calcium supplement and start breast-feeding the child.		
11.2	**Post Natal Inpatient care of New Born:** After delivery; all new born not needing special care shifted to the Labour ward with PW for postnatal care an Postnatal ward is kept warm (25°C). New Born is kept with PW on the same bed right from the birth. PW is encouraged to breast fed baby within 1 hr of delivery. Postnatal new born care includes review of labour and birth record, communication with PW, examination of baby, assessment of breastfeeding, cord care, skin & eye care, administration of Vit K, counselling of PW, immunization BCG, OPV-0, Hepatitis B (HB-1) and follow-up.		IMNCI Manual Guidelines for antenatal Care and Skilled birth attendance at Birth
11.3	**Shifting of Newborn to SNCU:** If the new born is has any of any of following condition it is shifted to new born care unit: • Birth weight <1800 gms, • Major congenital malformation • Severe Birth Injury • Severe Respiratory Distress • PPV≥ 5 Minutes • Needing Chest Compression or drugs • Any other indication decided by paediatrician. • New born is kept under closed observation • Birth Weight 1500-1800 • New Born needing IPPV • Vigorous babies with fast breathing	MO/Staff Nurse/ Paediatrician	IMNCI Manual
11.4	**Discharge of Patient:** Discharge is done after delivery, depending upon the PW's condition but not less than 48 hours for normal delivery. Discharge slip is prepared by the M.O. and entry is	Medical Officer/Gynaecologist/ Nurse in-charge	Discharge slip/ Antenatal Care and Skilled Birth Attendance at Birth

	made in the discharge register by ward in-charge. PW is briefed about postpartum care and hygiene, nutrition for self & Newborn, Exclusive breastfeeding follow-up advice, keeping baby warm, complete immunization of newborn postpartum visits, family planning. She is also counselled about the danger signs that should immediately reported to the hospital relating her and new born.		
11.5	**Payment to beneficiaries:** The payment under JSY is provided to the beneficiaries after 48 hour of stay in the hospital after delivery. The schedule of payment is informed to beneficiary by authorized personnel	Hospital Superintendent Clerk	JSY Scheme/ JSY Register
11.6	**Postnatal care after discharge:** Postnatal Care is provided through MCH/ Obstetrics & Gynaecology clinic PWs referred to hospital form postnatal visits by ASHA/ANM for postpartum complication like PPH and puerperal sepsis, severe Anaemia, breast complication & follow up of PPIUCD are assessed in OPD Clinic/ Emergency and admitted in the hospital if required.	MO/ Obstetrician	
11.7	**Immunization:** The hospital immunization facility under universal immunization programme for children/new born/neonates which includes all vaccines e.g. OPV, DOT, TT, BCG, Measles etc. and register is maintained in the department by Sister In-Charge. Details of immunization given are entered on PW and child protection card. Auto disable syringes are used for immunization. Any serious adverse event following immunization such as death, Hospitalization, disability and other serious events that are thought to be related with immunization are immediately reported to MS by Phone. Other Serious AEFIs such as anaphylaxis, TSS, AFP, encephalopathy, sepsis, event occurring in cluster are reported to district immunization officer within the prescribed time in prescribed format. All the serious AEFI are investigated by appropriate	Immunization Nurse/ ANM	Universal Immunization programme/ PW and Child Protection Card

	authorities and corrective action is taken. After each immunization parents are informed about- • What vaccine is given and it prevents what. • What are minor side effects and how to deal with them? • When to come for next visit • To keep PW and child protection card safe and bring it on next visit.		
11.8	**Counselling for the Family Planning:** The patient is referred from Obstetrics & Gynaecology clinic/MCH Clinic and other consultation rooms to the counselling centre (if any) of hospital or counselled in PP clinic The clerk enters patient's details in the register and asks the patient to fill consent form The MO explains the couple on importance of family planning and the various permanent (NSV, Vasectomy, Female sterilization, Tubectomy) and temporary methods of family planning (e.g. PPIUCD, Condoms)	MO/ PP Centre In charge	Family planning registers
11.9	**Emergency Triage Assessment & Treatment:** Any sick young infant or child received in hospital is promptly attended and standard ETAT procedure followed for management.	MO/ Paediatrician/ Nursing Staff	WI- Steps in Management Of Sick young Infants and Children.
11.9.1	Triage: Triage of all young infants and children is done in following categories as soon they arrive the hospital. • those Emergency signs (E) requiring Emergency Treatment • those Priority Signs (P) requiring rapid assessment and action • Non urgent (N) cases those can wait Triage is done by assessing Airway, Breathing, Circulation, Coma, Convulsion and Dehydration (ABCD). If no emergency sign is seen than priority signs are looked for.	MO/ Paediatrician/ Nursing Staff	WI- Triage
11.10	**Management of Low birth Weight Neonates:** All low birth weight Vit. K intramuscular at birth. Neonates with birth weight less than 1800 gms are admitted in the hospital.	MO/ Paediatrician/ Nursing Staff	WI for modes of providing fluid and feeding. Indication of

	Normal body temperature of neonate is maintained through Kangaroo Mother Care or through radiant warmer/ incubator as advised by the paediatrician. Fluids and nutrition is provided as per birth weight or gestation of the neonate.		Discharge of LBW neonates.
12	**Referral and Transport of Neonates:** If management of newborn cannot be done at the hospital either due to lack of facilities (neonatal care unit) or due to need of tertiary care management, neonate is referred to higher centre or other hospital. Receiving facility is communicated about the patient. Neonate is stabilized with respect to temperature, airway, breathing, circulation and blood sugar. A doctor/nurse/health worker is arranged for accompanying the neonate to receiving hospital if possible. Parents/attendants of newborn are communicated of new born and instructions are given for care of newborn during transport. A referral note is prepared and given to patient's attendants describing condition of new born, reason for referral and treatment given. about the condition.	MO/ Paediatrician/ Nursing Staff	
13	**Infection Control:** Standard Infection Control Measures are taken to ensure hospital acquired infections and safe work environment to prevent providers. These measures are as per Labour Room Standardization guideline and broadly includes: • Strict adherence to standard hand washing • Practices 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 and spills-management • appropriate handling of Biomedical Waste service • Regular culture surveillance of labour room is done to ensure safe patient care environment • Regular monitoring of Episiotomy site infection	Infection Control Nurse/ Staff Nurse/MO/ Obstetrician	Infection Control Manual / SOP for Hospital Waste Management/ SOP for Housekeeping Management/ National Infection Control Guidelines

	rate		
13.1	**Environmental Cleaning and Processing of equipment in Labour Room:** External foot wears are not allowed in the labour room. It mandatory to wear dedicated labour room sleepers before entering the labour room. After every procedure all working surfaces are disinfected. Only staff that is required for procedures is allowed in labour room. Traffic in labour room is kept minimal.	Housekeeping Staff/ Hospital Manager	Infection Control Manual SOP on Housekeeping
14	**Rights & Dignity of pregnant women:** Simple and clear language is used while communicating with pregnant women. Pregnant woman is informed about the status of her health and supported to understand options and make decisions. Woman is made to feel as comfortable as possible when receiving services. Before any examination permission is taken from pregnant women and procedure is explained to her. During the examination privacy of patient of pregnant women is maintained. Screens and curtains are provided in examination area and it is ensured that woman is protected from view of other people. Pregnant women consent is taken before discussing with her family or parents. Confidential information about pregnant women is never discussed with other staff members or outside the facility. Informed consent is taken before any invasive procedure. Any pregnant woman with HIV is not denied on basis of HIV status. Her HIV status is kept confidential except to people who are involved in care.	MO/ Staff Nurse/ Other Service Providers	
15	**Procedure for record maintenance including consent form:** All patients records including consent forms, store		

	inventories, equipment, annual maintenance documents, complaints, staff records, waste disposal records are well documented and kept in relevant files by Nurse supervisor. Written consent form must comply to the following requirements: • The name(s) of all the practitioner(s) immediately responsible for the patient is mentioned. • Diagnosis is mentioned. • A brief description of the recommended treatment or proposed procedure. • A statement that relevant aspects of the treatment, or procedure, including indications, benefits, risks, and alternatives including no treatment have been discussed with the patient in language that the patient could understand; and that the patient indicated comprehension of the discussion. • A statement that the patient had an opportunity to ask questions. • The date and time the discussion took place and whether the patient consented to the treatment or procedure. • The written signature of the practitioner writing the note (including the Practitioner's legibly written name). • Signature/Thumb impression of Patient/Next of Kin/Guardian as applicable and legible written name & relationship with the patient. • Date of Consent • Consent form is filled completely with no blank space/ box. • General consent is obtained at the time of admission, explaining the scope of such consent • All procedures performed on the patient have separate consent taken for each of the procedures. • Consent is signed by all the patients in Labour room. In case patient/ Next to Kin is illiterate then the thumb impression of the patient is taken which is witnessed by a neutral person. • All consent forms are maintained in the patient case file & are filed as such with the medical records department.		
	Monitoring & Quality Control		
16.1	**Maternal Death Surveillance Response:** All maternal deaths occurring in the hospital including	Treating MO, FNO, DNO	FBMDR Format Maternal

	abortion and ectopic gestation related deaths, in pregnant women and PWs after within 42 days of termination of pregnancy are informed immediately by treatingdoctor to facility nodal officer MDSR at the time of occurrence The facility nodal officer (FNO) of the hospital inform the district nodal officer (DNO) and subsequently to state nodal officer within 24 hours. Facility nodal officer fill the primary informant format and sent it to (DNO) Maternal death is immediately investigated by medical officer treating the PW using facility based maternal death review format and submit it in triplicate to FNO within 24 hours. A facility MDSR committee is constituted as per MDSR guidelines which reviews all maternal deaths occurred in monthly review meeting and suggest corrective action to improve the quality of care. Minutes of meeting of review meeting along with case summary are sent to district nodal officer.		Death Review Guidebook
16.2	**Quality Assurance of Referral Services:** Each woman who is referred to the district hospital is given a standard referral slip. This referral slip is sent back to the referring facility with the woman or the person who brought her after writing outcome of referral on it. Both the district hospital and the referring facility keep a record of all referrals as a quality assurance mechanism	Medical Superintendent	

ENSURING RESPECTFUL MATERNITY CARE

Points to remember and implement

- Ensure privacy of the woman in labour
- Avoid Performing harmful practices
- Provide complete information about the care provided to the patient
- Take informed consent
- Allow choice of position for birth
- Avoid Verbal abuse (insult, intimidation, threats, coercion)
- Provide choice of companion
- Provide continuous support during delivery and avoid abandonment of care (i.e. leaving the woman alone or unattended)
- Ensure confidentiality of the patient
- Allow drink and food during labor
- Provide liberty of movement during labor(e.g., walking, moving around)
- Avoid discrimination based on ethnicity, race, or economic status, including denial of admission due to illegal immigration status
- Keep PW and baby together 24 hours a day. Avoid unnecessary separation of PW and newborn after the birth
- Prevention of institutional violence against women and babies, including disrespectful. Avoid Physical abuse (slapping/hitting)
- Depriving the woman of services in the facility due to lack of payment demanded for it
- Avoidance of the overuse of drugs and technology (such as oxytocin augmentation, episiotomy, cesarean section, incubation, sonograms)
- Skin- to-skin contact of the newborn with the PW immediately after the birth for at least the first hour
- Promoting breastfeeding on demand
- Evidence based care that enhances & optimizes the normal processes of pregnancy, birth, and postpartum
- Other

OTHER

Incorporating training on the issue of labour and childbirth companionship, and on the importance of respecting women's autonomy in making decisions during labour and childbirth, into pre- and in-service training for health-care providers and hospital quality managers could be one effective route towards achieving and sustaining this change.

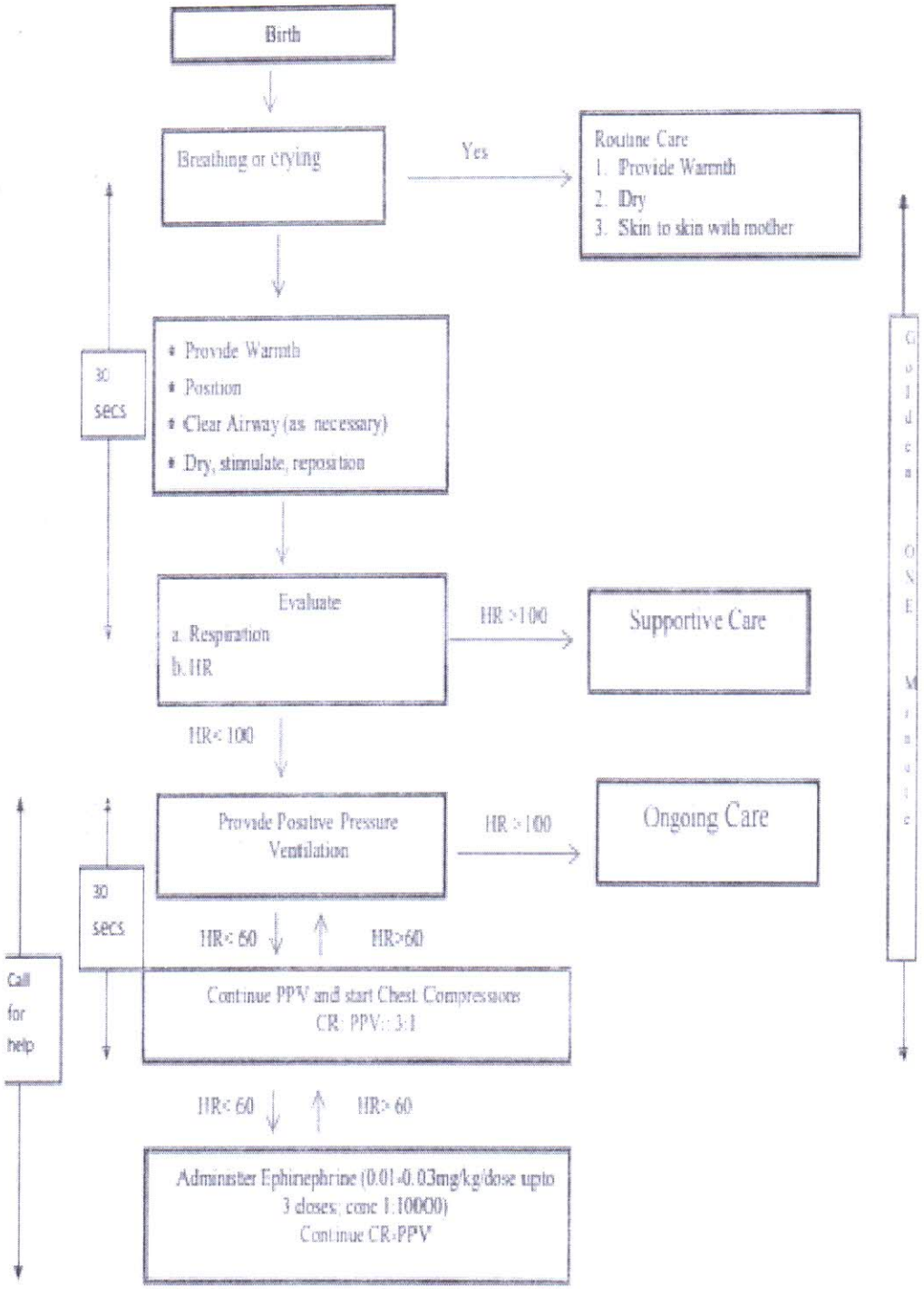
For implementation to be successful, it is crucial that health-care providers understand the benefits and potential caveats of labour companionship, as well as the importance of supporting pregnant women to decide whether they want a labour and childbirth companion, whom to choose and what role they want the companion to play on their behalf. A participatory approach is key to introducing labour companionship policies at the health-care facility.

Sensitization in communities and with women in particular is another important component of an implementation strategy for labour companionship, which will ensure that women are aware of their rights to select and have a companion and to make decisions related to their care during labour and childbirth.

- Provision of residence for PWs; active participation of parents in the care of hospitalized newborns; Parent training in newborn care; Siblings and grandparents visits;
- Hospital-based training in neonatal CPR;
- Prevention of excessive coercion—women being forced to undergo medical procedures.

A programme to allow women the support of a companion of choice during labour and childbirth can be implemented as a low-cost and effective intervention to improve the quality of care and ensure respectful maternity care.

Neonatal Resuscitation Program



* Endo-Tracheal Intubation can be considered at any level
**Consider stopping NNR if no detectable HR for 10 mins