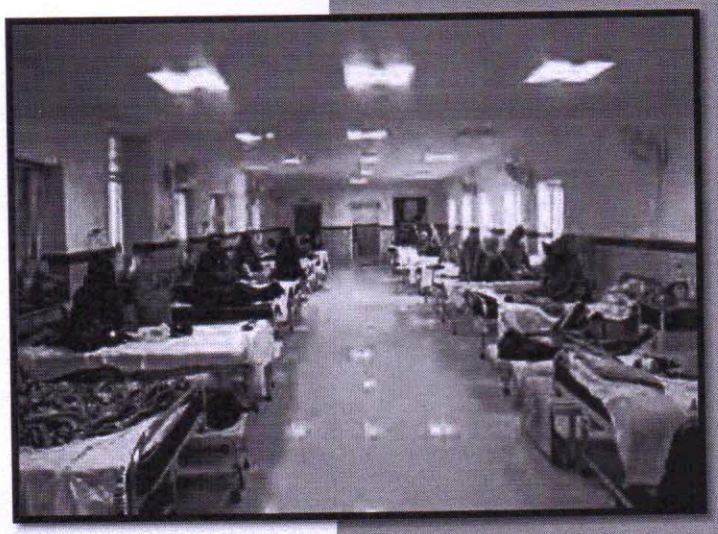
Standard Operating Procedures for District Women Hospitals- Uttar Pradesh

SOP- Maternity Ward



Quality Assurance Division
SPMU, NHM, Uttar Pradesh

Objectives of Maternity Ward

1. To ensure proper signages, directional arrows and proper IEC.
2. To ensure adequate stock and supply of drugs in the Maternity ward.
3. To ensure proper and prompt drug distribution.
4. To improve hygiene and cleanliness in ward as per IP & BMW management protocols
5. To ensure use of Personal Protection Equipments during all procedures
6. To maintain privacy confidentiality & dignity of client/ patient and empathetic & courteous behavior of the staff

SOP : Maternity Ward

1. **Purpose:**

- To establish, implement & maintain a system for patient admission in order to provide IPD services under JSY and JSSK offered by the hospital.
- To provide guidelines for General Nursing care with the aim that needs and expectations of patients are honoured.
- To provide guideline instructions for In Patient Medical Care Related Process with the aims that
  - ❖ Needs and expectations of patients are established,
  - ❖ Patient satisfaction is enhanced on continual basis, and
  - ❖ Feedback loop is established for continuous improvements.

2. **Scope:**

It covers all indoor patients under JSY & JSSK.

3. **Responsibility:**

Doctor, Matron, Nursing In-charge and Ward In-Charge, Housekeeping supervisor.

4. **Procedure:**

Sl. No.	Activity	Responsibility	Reference Document/ Record
4.1	**Admission**		
4.1.1	**Admission Advice** Patient visits the OPD/emergency for doctor's consultation. Depending upon the assessment, the doctor on duty advises admission (in writing on the OPD Slip)	Treating Doctor	OPD Slip, Patient Registration no. Doctor's Instruction for admission
4.1.2	**In-patient Registration-** Inpatient registration and allocation of beds is done as per the procedure. Orientation of patient and patient's attendants about hospital policy on visitors, visiting time and etc.	Registration Clerk	SOP for Patient Registration, Admission & Discharge Management, Bed Head Ticket.
	Receiving the patient in ward: Stable Patient is shifted to the maternity ward accompanied by an attendant. Stretcher/wheel chair/Trolley are used for shifting of patient as required.	Ward nurse	Registration slip Admission & Discharge register

Sl. No.	Activity	Responsibility	Reference Document/ Record
	Patient room / bed is readied – ensuring cleanliness and readiness Patient received in ward and escorted to bed. Patient name, ID number, consultant and treatment details on patient file are checked. Patient's name is entered into Ward Admission and Discharge register. **Bed Allotment** Bed is allocated to the patient and the bed number is recorded in BHT and admission register. Patient is oriented about the layout of ward with instructions on how to call the nurse in case of emergency. A cupboard/ bed side locker is allotted to the patient. In case of non availability of bed the ward nurse makes alternate arrangement for additional bed. **Patient Property –** Valuables like jewellery, mobile and cash are handed over to the patient relatives. Patient is instructed not to keep any valuables with them.		
	Initial Assessment- Once patient is settled in the ward, nurse conducts a nursing need assessment. Vital signs are checked and recorded She calls the duty doctor who conducts the initial assessment (if it is not done at Emergency/ OPD). Detailed history is taken and systemic examination is done and the findings/ directions are recorded in the BHT.	Doctor/on Duty Ward Nurse	BHT
	Initiation of Treatment, Requisition of diagnosis and receiving of the reports: Patient file is checked for investigations to be done and immediate treatment plan. For investigations – necessary investigations slips are made, signed, specimen taken, requests and sample sent to Lab.	Ward Nurse	Lab requisition slip Radiology requisition slip Pharmacy indent

Sl. No.	Activity	Responsibility	Reference Document/ Record
	For Radiology – request is filled and signed and sent to Radiology. Pharmacy request for drugs and consumables as prescribed in patient file. Dietician/ Kitchen personnel is informed for diet. Investigation reports are received – nurse signs under received column in lab register. Report is entered into patient case file on investigation sheet and report is placed in patient file. Patient treatment plan is reviewed, new additions / deletions to the plan are made, plan of treatment is discussed at length with patient, including possible length of stay, disease course, prognosis, medications, etc.		
4.2	**Shifting of Patient within the hospital** OT / ICU nurse in charge is consulted about bed / OT availability and informed about transfer. Stretcher/ wheel chair/ Trolley are used for shifting of patient as required. In case the patient has to be transferred to OT / ICU she is preferably accompanied by a doctor /Nurse.	On duty Nurse In charge	
	Procedure for transfusion of blood: Only Physicians are allowed to order blood components for transfusion. The ordering physician signature and stamp must appear on the blood requisition form. The form must be filled out in its entirety – including the diagnosis and date of the scheduled surgery. It must be stated whether it is urgent or routine with justification for urgency. Patient samples are drawn by laboratory or nursing personnel. The phlebotomist's signature has to appear on the tube's label (in such a manner that does not interfere with the legibility of the label) and on the order form.		

Sl. No.	Activity	Responsibility	Reference Document/ Record
	The phlebotomist's signature verifies that the patient has been properly identified and the label of the tube properly affixed. Safe blood transfusion requires accurate identification of patient and blood samples at all stages, from collection of the patient's sample to actual transfusion. In order to prevent transfusion reactions that may result from improper identification of the sample and patient, the following procedure must be strictly adhered to: 1. The patient's identification is verified with two identifiers viz. full name, address and husband's name 2. Identification of in-patients is to be verified only by the demographic data as shown on their medical records. The data on the patient file is matched with the details on the label of the tube and the blood requisition form. 3. The phlebotomist's signature is must on requisition form and the blood sample tube. Omission results in the tube being returned to the physician for signature. The request form for blood (or blood products) essentially includes patient's full name, Hospital admission /registration number, ward and bed no., and date of collection besides other information. The blood sample also has the above mentioned essential identification particulars. Improper or unlabelled samples are never sent. The responsibility for transfusion of blood products rests upon the treating physician. In accordance with the regulations of the Ministry of Health, two persons are responsible for ensuring the proper identification of the blood component and the patient. These may be a physician and a nurse/ two physicians. Verification of the unit label, the transfusion form and the patient identification is of paramount importance in preventing serious transfusion reactions and therefore performed without exception. a) The patient name and identity number as displayed		

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	on the patient's file is compared with the information on the blood bag and the transfusion form. b) In the comparison process, special attention is paid to the unit number and blood type as contained on the blood bag and the transfusion form. If there are any discrepancies, the unit is not transfused and returned to the Blood Bank. c) Informed consent is obtained from the recipient for the said transfusion. d) The information on the blood transfusion form is filled. The date and start-time for the transfusion are entered. Signatures of those verifying the identification of the patient and blood unit id are done. During the transfusion, the patient is observed for signs or symptoms of a transfusion reaction. e) At the conclusion of the transfusion, the date and time are entered and any information pertaining to an adverse reaction is noted. The upper portion of the perforated form is separated and placed in the patient's chart. The bottom portion is returned to the blood bank. In the event of a reaction, the portion of the form indicates the nature of the reaction and should be returned to the blood bank. f) All blood products are administered through a blood filter except for IV gamma globulin and albumin solutions. Transfusions begin no longer than 30 minutes after the product has arrived at the ward. g) The duration of the transfusion does not exceed four hours. The only permissible additive to the blood bag is normal saline (0.9%) h) Premedication prior to whole blood or packed cell transfusion is discouraged as it may tend to obscure a significant transfusion reaction. **TRANSFUSION REACTIONS** A. All transfusion reactions or suspected transfusion		

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	reactions are reported to the blood bank. Because the initial presentation of a serious transfusion reaction may appear similar to a minor reaction, discontinuation of the transfusion immediately is imperative in any case of suspected transfusion reaction. B. At the onset of a suspected transfusion reaction, the following procedure is performed: 1. Transfusion of the blood component is stopped immediately, and the infusion is kept open with normal saline. 2. The attending physician is notified immediately. 3. The patient identification and blood label on the blood component bag is re-checked. C. The decision to continue or discontinue the transfusion is made only by a physician in charge of the patient's care. In either case, the transfusion reaction is described as outline on the transfusion form accompanying the blood component and this is returned to the blood bank with the remainder of the component bag and the transfusion set along with a) A 3cc sample in EDTA (from the opposite arm drawn within half an hour) to the blood bank. b) A 5cc sample of clotted blood (as in a cross match) is collected within half an hour in a plain vial and sent to blood bank. Following are sent to the Hospital laboratory a) A first Voided urine sample for analysis of free hemoglobin. (Lab hemoglobin analysis) b) A blood culture from an unopened segment of the blood component bag (Blood Bank Technician)		
	Preparation of Patient for surgical Procedure: Please refer to Labour room SOP for the preparation of pregnant woman for surgical procedure. **Preparation of patient for other surgical procedures:** Pre Anaesthesia Check up (PAC) is done few days prior to surgery. Review PAC is done and pre medication advised on the evening prior to surgery. The day before the surgery, the patient is instructed to		

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	take a medication or drink a solution to empty the digestive tract in preparation for surgery. A preoperative cleansing of vagina (vaginal douche) may be done to reduce the risk of infection. Immediately before surgery, the patient is also given an intravenous antibiotic medication to minimize risk of developing an infection after the procedure. Pre operative Instructions 1. Nil orally after mid night 2. Written consent for surgery duly signed in presence of operating surgeon and signed by the operating surgeon. 3. Preparation of parts in OT 4. Operating site of patient is to be marked by skin marker pen 5. Skin sensitivity is done for iodine. Pre operative cleaning of skin is done with Betascrub 2 hours before sending the patient to OT and part to be wrapped in sterile towel. 6. Patients are given prophylactic antibiotics appropriate for their specific procedures. Pre operative prophylactic antibiotics to be started within 30 minutes to one hour before incision. Part preparation is done in OT (as advised) < Abdominal / Perineal Final skin wash is done with Betascrub followed by 10% Betadiene application and spirit.		
	Procedure for maintenance of rights and dignity of pregnant women: Patient rights are taken into consideration while providing services to the patient in maternity ward: The patient is given medical advice and treatment which fully meets the currently accepted standards of care and quality. The patient is informed about health care services available and what charges, if any, are involved. The patient is given a clear description of her medical		

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	condition and of the treatment proposed including common risks and appropriate alternatives. The patient is informed if she wants to know the names of any medication to be prescribed, and its normal actions and potential side- effects if any. The patient is allowed to take a second medical opinion. The patient's dignity, religious and cultural beliefs are respected. The right of access to medical information that relates to your condition kept confidential. The patient's information relating to her medical condition is kept confidential. All support is provided if a patient wants to make complaint / suggestion through channels and the complaints are dealt with promptly and fairly. <u>Patient's Privacy</u>: Screens, curtains, examination room, injection/treatment room and breast feeding corners are available to maintain patient's privacy.		
4.6	**Maintenance of record including Consent** Medical records are to be maintained in a manner that is current, detailed, organized, and easily accessible. All patient data should be filed in the medical record, (i.e. lab reports, x-ray reports, consultation notes, etc.) All entries in record are as per following: • Unique identifier of patient on every document page. • Done by concerned medical care professionals • Written in blue / black indelible ink for handwritten documentation. No pencil entries. • Dated and signed (include day, month, and year). Timing of entries is required on Medication Administration, Peri-Operative, and Nursing documentation.	Sister In charge/ Medical Officers/ Specialists/ Dietician/ Technician/	Patient File, BHT, Admission Discharge register, Linen register, Diet register, Death register, Procedure register, General Order Book, Consent Format

Sl. No.	Activity	Responsibility	Reference Document/ Record
	• Legible and include clear, concise and pertinent patient information. • Transfer records (inter-hospital and intra-hospital) • All disciplines document according to discipline specific documentation standards. • Entries written in error has a single line drawn through and "ERROR" written above. Staff never erases, obliterates or uses liquid paper correction fluid on a patient's record. • All forms in the record are approved by appropriate authorities. • No part of the medical record is ever to be removed after entry. • The patient's name and medical record number appears on every record page/document in the medical record. • Rubber stamps are not allowed for physician signatures. • Written Signatures validate written orders and written notes. • Inpatient Care is documented in the Medical Record and includes: ▪ Reason for admission, diagnosis, plan of care are included in the documents. ▪ Evidence of the initial patient assessment and all subsequent re-assessments. ▪ Documentation of interventions based on physician orders and/or on unit standards of care or approved protocols. ▪ Documentation of nursing care is provided. ▪ Any operation /Procedure performed in detail. Name, signature, date and time on every entry made in the record. ▪ The records are legible. o The records are in a chronological order demonstrating the continuity of care. o Transfer notes are in accordance to the policy of transfer and include- date and time ▪ Medication administration is recorded. ▪ Specific care provided is evidenced on the patient care flow sheet. ▪ Reason for discharge and name of the receiving hospital. ▪ Death certificate copy ▪ Authenticated. Signature and professional title. ▪ Aspects of patient care during operative or		

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	other invasive procedures, in the emergency department, the dialysis unit and obstetrics is documented on forms specific to each specialized area. ▪ Patient discharge instructions ▪ Discharge summary is prepared and signed or countersigned by the clinician incharge. ▪ Death summary includes – cause of death, date, time and should bear the signature of the clinician incharge. ▪ The medical notes by the resident doctors are countersigned by the clinician in-charge within 24 hrs. The medical records are reviewed and audited periodically and used as a tool for quality improvement of clinical services. A medical audit committee is composed for this who shall audit the records on half yearly basis. o Appropriate sample of the medical records is selected for audit. The sample is based on statistical principles and representative of all records. Adequate mix of active and discharge cases are kept in sample o The medical audit findings are kept confidential and circulated only to the care providers. o Patients and staff anonymity are maintained in medical audits o Based on the findings in medical audit, Medical Audit Committee takes appropriate corrective and preventive actions. General Admission consent is signed by all the patients admitted in the ward. In case patient is illiterate then the thumb impression of the patient is taken which is witnessed by a neutral person. **Informed Consent for procedure**: The consultant in charge of the case is responsible for informing the patient &/or attendant about the nature of the surgical procedure being done, the expected benefit there of and the risks associated with the procedure. Signature of the patient is obtained on the Informed consent form, which is countersigned by the doctor. In case the procedure is to be filmed / photographed,		

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	specific consent of the patient is obtained.		
4.7	**Procedure of Discharge:** Decision for Discharge: Decision is made by the Consultant to discharge the patient in the next 24 hours and entry is done in patient's file / case record and order is given to medical officer to prepare provisional discharge summary. Provisional discharge summary is made on the basis following documents – ▪ History record sheet ▪ Physical examination ▪ Progress sheet ▪ Investigations record On the day of discharge, confirmation of patient discharge is done. Patient counseling before discharge – diet, medications, follow up procedure etc., as in discharge summary, is discussed with patient and patient's attendants. Patient's follow up visits are pre scheduled by Primary treating consultant. LAMA Patients: If patient's attendants / patient want to take discharge against medical advice, then LAMA consent is taken by the patient on his file record/BHT. The clinician explains the consequences of this action to the patient/ attendants and the same is documented. Discharge summary is provided to the patient.		
4.8	**Priority of treatment –** If an admission is done from the OPD or from casualty on urgent basis life saving treatment/ procedures supercedes any documentation work.	Doctor/on Duty Ward Nurse	
4.9	**Orphan/ *'Lawaris'* Patients –** Orphan patients not having any accompanier/ relative are specially monitored. Efforts are made to appoint some local NGOs/ volunteers who can take care of non clinical needs of	Doctor/on Duty Ward Nurse	

Sl. No.	Activity	Responsibility	Reference Document/ Record
	these patients. Names of all such patients are reported to local police.		
4.10	**People living with HIV/AIDS** Confidentiality of such patient is be maintained in all cases. Patient is not isolated / segregated. Beds / BHT of such patients are labelled or marked with code which denotes their HIV positive status. Status of such patients is not discussed with anybody who is not involved in direct care of patient.	Doctor/on Duty Ward Nurse	
4.11	**Inpatient Care**		
4.11.1	**Post Natal in-patient Care of Mothers** After delivery, mother is shifted to the labour ward for post-natal care • Maternal health is monitored and every step shall be taken to improve well being and good health of mother & new born. • Medication is administered when required and prescribed by the doctor. • The patient is encouraged for taking normal diet, plenty of fluids and start breast feeding the child.	Staff Nurse	SOP for IPD Management
4.11.2	**Post Natal in-patient care of New Born** After delivery; all new born not needing special care shifted to the Labour ward with mother for postnatal care and Postnatal ward is kept warm (25°C). New Born is kept with mother on the same bed right from the birth. Mother is encouraged to breast feed baby within 1/2 hr. of delivery. Postnatal new born care includes review of labour and birth records, communication with mother, examination of baby, assessment of breastfeeding, cord care, skin & eye care, administration of Vit. K, counselling of mother, immunization BCG, OPV-0, Hepatitis B (HB-1) and follow-up.	Nurse on duty	F. IMNCI Manual Guidelines for antenatal care and skilled birth attendance at Birth
4.11.3	**Shifting of Newborn to SNCU** If the new born has any of the following conditions he/	MO/Staff Nurse/	F. IMNCI Manual

Sl. No.	Activity	Responsibility	Reference Document/ Record
	she is shifted to new born care unit: • Birth weight < 1500 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 gms • Vigorous babies with fast breathing	Paediatrician	
4.11.4	**Discharge of Patient** Discharge is done after delivery, depending upon the mother's condition but not before 48 hours in case of normal delivery Discharge slip is prepared by the M.O. and entry is made in the discharge register by ward in-charge. Mother is briefed about postpartum care and hygiene, nutrition for self & Newborn, Exclusive breastfeeding follow-up advice, keeping baby warm, complete immunization of newborn, post partum visits, family planning. She is also counseled about the danger signs related to herself and the newborn that should immediately reported to the hospital.	Medical officer/ gynaecologist Nurse In-charge	Discharge slip Antenatal Care and Skilled Birth Attendance at Birth
4.12	**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
5	**JSY and JSSK**		
	For pregnant women following Free Entitlements are provided under JSY and JSSK Yojana: ▪ Free and cashless delivery ▪ Free C-Section ▪ Free drugs and consumables ▪ Free diagnostics ▪ Free diet during stay in the health institutions ▪ Free provision of blood ▪ Exemption from user charges		

Sl. No.	Activity	Responsibility	Reference Document/ Record
	▪ Free transport from home to health institutions ▪ Free transport between facilities in case of referral ▪ Free drop back from Institutions to home **The following are the Free Entitlements for Sick newborns up to one year after birth. This has now been expanded to cover sick infants**: ▪ Free treatment ▪ Free drugs and consumables ▪ Free diagnostics ▪ Free provision of blood ▪ Exemption from user charges ▪ Free Transport from Home to Health Institutions ▪ Free Transport between facilities in case of referral ▪ Free drop Back from Institutions to home		
6	**Infection Control**		
	Responsibility of IC nurse: • To ensure proper infection control measures. • To identify problems in implementation of infection control polices and provide solutions. • To monitor the following practices on daily basis: a) Bio Medical Waste. b) Autoclave log book in OT. c) Linen segregation is done or not (dirty and contaminated). d) Hand washing. e) Sharp disposal in wards. f) Use of needle cutter. g) Preparation of Hypochlorite solution • To provide training of paramedical staff including nurses and housekeeping staff.	**Chairperson Infection Control Committee**	
	Meeting of Infection Control Committee The infection control Committee meets once in a month and otherwise as necessary. In-charge of Infection Control Team keeps the Management Review Team updated on the status of Infection in the Hospital.		Minutes of meeting
	Food Handlers Screening of food handlers is done **bi-annually.** Samples include nasal swabs and stool samples. Records to be maintained by Kitchen In-charge.	Kitchen I/C and Lab attendant	

Sl. No.	Activity	Responsibility	Reference Document/ Record
	Drinking Water Bacteriological surveillance is done **monthly** from govt. recognized water testing laboratory. Records maintained by Pathology Department.	Sanitary Inspector/ Maintained supervisor and Lab attendant	
	Staff health plan: To control spread of infection from staff to patient or to protect staff from occupational hazards annual medical check-up of staff is done. Vaccination for Hepatitis B/ any other immunization required is provided to all staff members.	Hospital infection control committee	
	Hand Hygiene: Adequate hand washing facility is available in all patient care areas. Elbow operated taps, washbasin and soap are available in service provider's room & in the in-patient care areas. If water facility is not available alcohol based hand rubs are provided in patient care area. Scrub area is available outside the OT / LR with elbow operated or foot operated water tap facilities.	On duty doctor, staff nurse and all paramedic as well as housekeeping staff involved in patient care.	
	Disinfection: Disinfection of equipment and furniture is carried out with bleaching powder solution at least once a day or as required.	Housekeeping staff or General duty attendant	
	Housekeeping: Cleaning of walls, floors, tables and fixtures is dones per a schedule programme at pre-determined intervals and appropriate disinfectant is used for cleaning. (*Procedure 20, Hospital housekeeping & General Upkeep Management)* Biomedical waste is collected, segregated, transported, stored and disposed off as per BMW management & handling rule, 2016. (*Procedure 24, Hospital Waste Management)*	Housekeeping staff	Housekeeping Check list Biomedical waste Management & handling rule, 1998.
	Antibiotic policy: Antibiotic policy is adopted to monitor and control irrational use of antibiotics leading to multi-drug	Infection Control Committee.	

Sl. No.	Activity	Responsibility	Reference Document/ Record
	resistance and to promote the use of antibiotic policy in clinical practice. Method: • Identification of relevant pathogens in exudates and body fluid collected from patients. • Sensitivity test is done to determine the degree of sensitivity or resistance of pathogens. • Antibiotic with higher efficacy, low side effect and less chances of anti-microbial resistance is used in the hospital.		
	Procedure for sorting, cleaning and distribution of clean linen to patient: Refer to SOP Laundry services **Soiled linen:** All soiled linen is considered potentially infected and treated accordingly. Soiled linen is stored and collected separately. It is not mixed with used linen. Soiled linen is disinfected with 0.1% bleach solution before sending it to laundry. All used and soiled linen are handled with personal protective equipments by the staff.	Ward I/C and Laundry supervisor	
	Use of Personal Protective Equipment's Staff has been trained to use personal protective equipment when handling blood, body substances, excretions and secretions; <u>Personal Protective Equipment includes</u>: · Gloves; · Protective eye wear (Eye shields/goggles); · Mask; · Apron; · Gown; · Boots/shoe covers; and · Cap/hair cover	The entire healthcare worker involved in patient care and relatives of patient visiting isolation wards/ ICU.	
	Protection against injury with sharps Precautions to be observed: • Needles are not recapped, bent or broken by hand. • Disposable needles & other sharps are discarded into puncture proof containers • Sharps are not passed from one HCW (Health Care Worker) to another by hand. Injection tray/ trolley is used to transport sharps. • All sharps containers are discarded when 3/4th full.		

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	Infection Control Audit The infection control audit is carried out on a regular basis. Timely actions are taken against the observations raised during the audit. The Infection Control team members conduct inspection periodically. Records are maintained by convenor of infection control Committee.	Infection Control Committee.	Infection Control Audit Check list

5. Records:

Sl. No.	Name of Records	Record No.	Minimum Retention Period
1	Immunization Register		
2	Birth Register		
3	Still Birth Register		

6. Process Efficiency Criteria:

Sl. No.	Activity	Process Efficiency Criteria	Benchmark/Standard/Target
1	Clinical Care	Maternal Mortality Rate	
2	Clinical Care	Newborn Mortality Rate	
3	EOC Services	C-Section Rate	
4	EOC Services	No. of deliveries conducted in the night	
5	Antenatal Care	Proportion of mothers provided four or more ANCs	
6	Intra partum	Labour Room Score	
7	Antenatal Care	Door to drug time for antenatal visit	
8	Intra partum Care	Percentage of deliveries for which partograph is prepared.	
9	New born Care	No. of new born resuscitated	
10	JSY	Percentage of mothers leaving hospitals within 48 hours.	

7. Reference Documents

1. Guideline for pregnancy care and management of obstetrics complications for MO- MoHFW
2. SBA Guidelines for Antenatal Care and Skilled Attendance at Birth- MoHFW
3. Operational Guidelines on Maternal & Newborn Health - MoHFW
4. Facility Based IMNCI- Participant Manual- MoHFW
5. Infection Control Practices in Emergency Obstetric Care –Engender Health
6. Infection Prevention Guidelines- JHPIEGO
7. Immunization Hand Book for Medical Officers- MoHFW
8. Managing complication in Pregnancy and Child Birth- WHO
9. Maternal Death Review Guidebook – MoHFW
10. Operational Guidelines for JSSK
11. Procedure for admission Discharge Management
12. Biomedical waste Management & handling rule, 1998
13. Infection Management & Environment Plan (IMEP) Guidelines – MoHFW
14. Practical Guidelines for Infection Control in Health Care Facilities – WHO