STANDARD OPERATING PROCEDURE

DEPARTMENT OF OBSTETRICS AND GYNAECOLOGY

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1. RESPECTFUL MATERNITY CARE:

THE UNIVERSAL RIGHTS OF CHILDBEARING WOMEN

The Distinctive Importance of the Childbearing Period: In every country and community worldwide, pregnancy and childbirth are momentous events in the lives of women and families and represent a time of intense vulnerability. The concept of "safe motherhood" is usually restricted to physical safety, but childbearing is also an important rite of passage, with deep personal and cultural significance for a woman and her family. Because motherhood is specific to women, issues of gender equity and gender violence are also at the core of maternity care. Thus, the notion of safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, including respect for women's autonomy, dignity, feelings, choices, and preferences, including companionship during maternity care.

By design, this document focuses specifically on the interpersonal aspects of care received by women seeking maternity services. A woman's relationship with maternity care providers and the maternity care system during pregnancy and childbirth is vitally important. Not only are these encounters the vehicle for essential and potentially lifesaving health services, women's experiences with caregivers at this time have the impact to empower and comfort or to inflict lasting damage and emotional trauma, adding to or detracting from women's confidence and self- esteem. Either way, women's memories of their childbearing experiences stay with them for a lifetime and are often shared with other women, contributing to a climate of confidence or doubt around childbearing.

Growing Evidence of Disrespect and Abuse

Imagine the personal treatment you would expect from a maternity care provider entrusted to help you or a woman you love give birth. Naturally, we envision a relationship characterized by caring, empathy, support, trust, confidence, and empowerment, as well as gentle, respectful, and effective communication to enable informed decision making. Unfortunately, too many women experience care that does not match this image. A growing body of research evidence, experience, and case reports collected in maternity care systems from the wealthiest to poorest nations worldwide paints a different and disturbing picture. In fact, disrespect and abuse of women seeking maternity care is becoming an urgent problem and creating a growing community of concern that spans the domains of healthcare research, quality, and education; human rights; and civil rights advocacy.

In 2010, a landscape report by Bowser and Hill, Exploring Evidence for Disrespect and Abuse in Facility- based Childbirth, summarized the available knowledge and evidence on this topic.i While the review revealed a relative lack of formal research on the topic, the authors' in- depth search of published and technical literature as well as interviews and discussions with content experts described seven major categories of disrespect and abuse that childbearing women encounter during maternity care. These categories overlap and occur along a continuum from subtle disrespect and humiliation to overt violence; they include physical abuse, non- consented clinical care, non- confidential care, non- dignified care (including verbal abuse), discrimination based on specific patient attributes, abandonment or denial of care, and detention in facilities.

Interpersonal care that is disrespectful and abusive in nature to women before, during, and after birth is appalling because of the high value societies attach to motherhood and because we know the intense vulnerability of women during this time. All childbearing women need and deserve respectful care and protection of their autonomy and right to self- determination; this includes special care to protect the mother- baby pair as well as women in a context of marginalization or heightened vulnerability (e.g., adolescents, ethnic minorities, and women living with physical or mental disabilities or HIV). Furthermore, disrespect and abuse during maternity care are a violation of women's basic human rights.

Assertion of the Universal Rights of Childbearing Women :Human rights are fundamental entitlements due to all people, recognized by societies and governments and enshrined in international declarations and conventions. To date, no universal charter or instrument specifically delineates how human rights are implicated in the childbearing process or affirms their application to childbearing women as basic, inalienable human rights. This aims to address the issue of disrespect and abuse among women seeking maternity care and provide a platform for improvement by

- Raising awareness of childbearing women's inclusion in the guarantees of human rights recognized in internationally adopted United Nations and other multinational declarations, conventions, and covenants;
- Highlighting the connection between human rights language and key program issues relevant to maternity care;
- Increasing the capacity of maternal health advocates to participate in human rights processes;
- Aligning childbearing women's sense of entitlement to high- quality maternity care with international human rights community standards; and
- Providing a basis for holding the maternal care system and communities accountable to these rights.

By drawing on relevant extracts from established human rights instruments, the Charter demonstrates the legitimate place of maternal health rights within the broader context of human rights. Seven rights are included, drawn from the categories of disrespect and abuse identified by Bowser and Hill (2010) in their landscape analysis (see table). All these rights are grounded in international or multinational human rights instruments, including the Universal Declaration of Human Rights; the Universal Declaration on Bioethics and Human Rights; the International Covenant on Economic, Social and Cultural Rights; the International Covenant on Civil and Political Rights; the Convention on the Elimination of All Forms of Discrimination Against Women; the Declaration of the Elimination of Violence Against Women; the Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights; and the United Nations Fourth World Conference on Women, Beijing. National instruments are also referenced if they make specific mention of childbearing women. Each right is sourced to the relevant instruments.

Tackling Disrespect and Abuse: Seven Rights of Childbearing Women

	Category of Disrespect and Abuse	**Corresponding Right**
1	Physical abuse	Freedom from harm and ill treatment
2	Non- consented care	Right to information, informed consent and refusal, and respect for choices and preferences, including companionship during maternity care
3	Non- confidential care	Confidentiality, privacy
4	Non- dignified care (including verbal abuse)	Dignity, respect
5	Discrimination based on specific attributes	Equality, freedom from discrimination, equitable care
6	Abandonment or denial of care	Right to timely healthcare and to the highest attainable level of health
7	Detention in facilities	Liberty, autonomy, self- determination, and freedom from coercion

In seeking and receiving maternity care before, during, and after childbirth:

ARTICLE I: Every woman has the right to be free from harm and ill treatment
International Standards
• Declaration of the Elimination of Violence Against Women, 1994, Article1 • International Covenant on Civil and Political Rights (ICCPR), 1966, Article7 • International MotherBaby Childbirth Initiative: A Human Rights Approach to Optimal Maternity Care,2010,Article9 • International Planned Parenthood Federation Charter on Sexual and Reproductive Rights, 1996, Article12 • Universal Declaration on Bioethics and Human Rights, 1997, Article 4
Multinational and National Standards
European Charter of Patient's Rights, 2002, Article9 • Ley Orgánica sobre el Derecho de las Mujeres a una Vida Libre de Violencia de Venezuela, 2007, Article 15j

ARTICLE II: Every woman has the right to information, informed consent and refusal, and respect for her choices and preferences, including companionship during maternity care
International Standards
• International Covenant on Civil and Political Rights (ICCPR), 1966, Article7,19 • International Planned Parenthood Federation Charter on Sexual and Reproductive Rights, 1996, Article6 • International MotherBaby Childbirth Initiative: A Human Rights Approach to Optimal Maternity Care,2010,Article3,4 • Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights, 2010 • Universal Declaration on Bioethics and Human Rights, 1997, Article 6
Multinational and National Standards
• Birth Justice as Reproductive Justice, NAPW, 2010 • Charter of Fundamental Rights of the European Union, 2000, Article 3.2, 7 • Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, 1997,

Article5

- Declaration on the Promotion of Patients' Rights in Europe, 1994, Articles 1.5, 2, 3, 4.6, 5
- European Charter of Patient's Rights, 2002, Article 3, 4, 5, 12
- Ley de Acompañamiento durante el Trabajo de Parto, Nacimiento y Post- parto de Puerto Rico, 2006,Article3e,3f
- Ley de Parto Humanizado—Ley Nacional No. 25.929 de Argentina, 2004, Article 2f, 2g
- The Rights of Childbearing Women, Childbirth Connection 1999, 2006, Articles 3, 4, 5, 6, 9, 12, 13, 14, 16, 19

We as Professor, Associate professor, Assistant professor, Medical officers, Postgraduate students& Resident doctors, Undergraduate students, Interns, Nursing staff, Dais. Class IV staff & all others directly or indirectly concern with women's care at our medical college hospital, Ahmednagar are abide with rights of women charter.

We will try our best for giving Safe Motherhood & Respectful Maternity Care to all coming to our health care facility.

We all have a role in Women's Respectful Health Care!

The White Ribbon Alliance, For Safe Motherhood.

2. RESPONSIBILITY MATRIX

(GYNECOLOGIST)

GENERAL

1. Be self-motivated and aware of current trends in the field
2. Be able to work in a multi-cultural environment
3. Abide by the code of Medical Ethics and rules and regulations of the Medical Staff and those specific to the department.
4. Participate in the on-call duties as required by the department.
5. Share workload in her specialty during the absence of her colleagues.
6. Ensure the staff punctuality.
7. Ensure the cleanliness of the Department.
8. Ensure the regular maintenance of biomedical and non-biomedical equipment.
9. Ensure the regular supply/replenishment of medicines.
10. Ensure the availability of medicines and functional equipment for emergencies at all times.
11. Provide technical assistance for purchase of new equipment / instruments needed from
12. time-to-time in the Department.
13. Participate in the forward planning, and further development of the department.
14. Ensure the compliance of Minimum Service Delivery Standards.
15. Allocate duties to other specialists/doctors from within the defined framework of particular JDs
16. Conduct evaluation based on achievements against set targets.
17. Write objective and unbiased Performance Evaluation Reports (PERs) of subordinate staff.
18. Inform MS about the matters which need his/her attention.
19. Ensure complete record of departmental statistics and report to the MS.
20. Perform outreach duties to the primary healthcare facilities and community services as and when required.
21. Participate in hospital committees meetings as requested.
22. Participate in disaster management inside the hospital, when indicated.
23. Perform other applicable tasks and duties assigned by MS within the capacity of her knowledge, skills and abilities, within the hospital and/ or affiliated medical facilities.

CLINICAL

1. Senior Gynecologist shall be the Head of the Obstetrics & Gynecology Department.
2. Conduct antenatal and Gyne OPD with her team regularly on specified/notified days and time as per policy.
3. Exercise the highest possible standards of patient care according to her clinical privileges and available resources.
4. Supervise and ensure preparation of OT list by the residents.
5. Plan and perform elective surgeries on specified daysand time as per policy.
6. Perform emergency gynecological/obstetrics surgeries on patients admitted through A&E Department
7. Conduct complicated deliveries herself or under supervision.
8. Ensure post- delivery, post-natal, neonatal care, advice on family planning, dietary advice and post-operative care of patients inward.
9. Write post-operative notes and post-operative instructions after each procedure.
10. Take daily round of the wards along with duty WMOs and staff Nurse for detail follow- up of the admitted patients.
11. Ensure that treatment prescribed is being administered to the patients.
12. Attend the patients with Gynecological problems admitted in other wards as and when requested.
13. Explain the patients about the use and effects of prescribed drugs.
14. Refer the patients to other specialists within the HCE and/or to higher level facilities if needed.
15. Review referrals from other specialists and from the lower health facilities to establish diagnosis and proper management.
16. Participate actively in approved research projects.

PREVENTIVE /PROMOTIVE

1. Ensure compliance of SOPs, particularly on Infection Control and Waste Management in the OPD, labor room, wards, operation theatres, pre and post-operativewards.
2. Ensure the sterilization of equipment and surgicalinstruments.
3. Ensure that all staff participating in the procedures is physically well protected by wearing proper dress: gowns, masks, caps, gloves andshoes.
4. Educate staff and patients on the prevention of UTI andSTIs

5. Advice mothers on family planning and child spacing during antenatalvisits.
6. Participate in the establishment and conduct of medical camps pertaining to MCH and FP activities
7. Recommend dietary, physical therapy and other rehabilitative measures to women in the post-natal and post-operative period for early return to normallife.

CAPACITYBUILDING

1. Participate in Training Programs related to skill development, Quality assurance and continuing medicaleducation.
2. Be committed for learning and training in pursuance of a career in Obs &Gynae.

DUTYROTA

1. Duty roster has the cover of consultants. Monthly duty roster of the department made by HOD OBs & Gyne will be submitted to the administration a week before the start of the month for information andapproval.
2. Duty roster shall cover the following areas: duties at following differentplaces.
    - OPD DutyRoster
    - Indoor DutyRoster
    - Emergency DutyRoster
    - 24/7 on-call Roster of Consultants
3. In the event that a doctor cannot attend the duty, the doctor will inform the immediate supervisor two days in advance so that appropriate measures may be taken to ensure that there is an HCP onduty.
4. The roster of on-call Anesthetist must also be displayed in the department for emergency surgeries.
5. The doctors on duty must be physically present in the ward during their dutyhours.
6. The doctor may leave the ward only after properly handing over thecharge.
7. Doctors must communicate with each other at the time of change ofdutyi.e. they should handover the patient to next doctor on duty. The information should be accurate, complete, concise, current and confidential

3. OUTPATIENT WORKPROCESS

3.1 GYNAECOLOGY OPD

Every Monday to Saturday from 9.00 am – 5.00 pm, or till the last patient's arrival.

OPD REGISTRATION PAPER- FIRST VISIT :

Detailed history on the first visit has to be taken .

- Pap smear has to be taken(for new patients)-except for unmarried and pregnant patient.
- For old patients, Pap smear report has to be traced.
- Availability of the following items in the examination room have to be checked-Sterile instruments, Sterile gloves , Cotton & Light.
- Female attendant has to be present.
- General examination, Systemic examination, Per abdomen, Local examination of the genitals,Per vaginal/ bimanual examination has to be done.
- After history taking and general examination case should be informed to senior resident or assistant professor and further examination should be carried out in their presence.
- High risk cases shuld be informed to consultant (Associate/ professor)
- Provisional Diagnosis has to be made. Symptomatic treatment has to be given.
- Investigations has to be advised.
- Next follow up date and day has to be given.
- Prescription should be written in given format with complete details of patient. It should be signed by residents with their respective stamp.
- Prescription of drugs which are not available in the hospital has to be given in MCI format only.
- Whenever admission is required, the patient and relatives have to be counselled for admission to Gynaec ward.
- Relatives should be directed about where to go.
- Patient who is unable to walk to ward or who is seriously ill should be shifted on wheel chair or trolley from OPD or Labour room to Gynaec ward with accompanying person.
- Advice about subsequent visits has to be given.

Patient for operative procedure :

- All investigations should be checked.
- Pap smear report have to be checked. Fitness for anaesthesia has to be checked.
- References have to be made for co-morbidity.
- Appointment for admission has to be given based on LMP either pre-menstrual or
- postmenstrual. The patient's name, phone number, LMP and the procedure to be done have
- to be entered in the OT diary

3.2 SPECIALITY OPD

- Speciality clinic will be run as per schedule by respective units.
- Every month duty roaster for consultant in charge, and residents will be made.
- Separate register has to be kept in OPD for entering patient's details with respective Unit.
- All the required details of the patients attending speciality OPD should be entered in respective register.
- Respective Unit should submit their speciality clinic statistic at the end of every month.
- Irrespective of the day, all women's should be examined by unit on duty. She can be asked to come for follow up on respective day of that speciality clinic.

Sr. no	SPECIALITY clinic	day
	High risk Antenatal Clinic	Monday – Saturday
	Family Welfare Clinic	Monday- Friday
	Postnatal Clinic	Monday – Saturday
	Infertility clinic	Tuesday & Thursday
	Cancer detection clinic	Friday & Saturday

3.3 ANTENATAL OPD

General

- Every Monday to Friday from 9.00 am to 5.00 pm, on Saturday till 1.00 pm has to be strictly followed.
- All woman should be respectfully treated for their illness.
- Rest of the days, routine OPD and L.R doctors has to examine all antenatal women
- requiring OBGY consultation.

NEW REGISTRATION (FIRST VISIT TO ANTENATAL OPD)

- detailed history has to be taken.
- Age, married since, Chief complaints, menstrual history LMP/EDD, Medical & Surgical history,Family history, history of previous hospitalization, history of hospitalization in present pregnancy, history of blood transfusion, Immunization history.
- Obstetric History of previous pregnancy and abortion in chronological order, duration of pregnancy, Labour-spontaneous/induced, duration of labour, mode of delivery and outcome-live/stillborn,if operative – indication, type of anaesthesia/place of previous operation, birth weight and sex , present health of child, ante/intra/postpartum complication and abortion, details like period of gestation, spontaneous / induced, medical / surgical, place of delivery.
- History of Contraception usage.
- Categorisation of high risk in present pregnancy. -High Risk pregnancy stamp if required(Red ink stamp)
- General Examination: Temperature, pulse, blood pressure, pallor, oedema, cyanosis, icterus, thyroid swelling.
- Systemic Examination: Cardiovascular system, Respiratory system, Central nervous system, others.
- All ANC cases will be informed to Assistant professor and obstetric examination will be carried out in their presence.
- All high risk cases will be informed to Associate professor and above.
- Informed consultant will countersign the OPD notes of residents after adding any points if needed.
- Prescription in MCI prescription format.

- Give symptomatic treatment, advice investigation provide Investigation forms along with advice regarding diet, nutrition, warning s/s of pregnancy, FS/FA & Calcium supplementation.
- Next follow up date given along with counselling regarding Breast feeding & Contraception.
- Make awareness of JSSK scheme.

ADDITIONAL THINGS TO CHECK

FIRST TRIMESTER

- TSH, USG-dating scan, NT Scan, double marker in high risk cases, GCT along with routine antenatal investigations Folic acid supplements.

SECOND TRIMESTER

- Immunisation status (give first dose as TT and second dose Tdap)
- Malformation scan
- Prenatal Screening for chromosomal anomalies by NT scan, triple & quadruple marker.
- Blood sugars / GCT.
- Haematinics and calcium supplements.
- Routine deworming in case of Anaemia - TabAlbendazole 400 mg. single dose in second trimester.
- Tab calcium 1000 mg. OD .
- Vitamin D 3 500 IU Daily OD.
- Tab Iron + Folic Acid till 6 months after delivery.

THIRD TRIMESTER:

- Blood sugars, Immunization status & Anti D prophylaxis in non-sensitized Rh negative mother,
- Pelvic adequacy : 38 weeks or later, in eligible patients

SUBSEQUENT ANC VISIT

- Check date and stamp, weight, Urine albumin on every visit.
- History: High/low risk: high risk pregnancy label. If missed, Weeks of gestation by dates/scan
- Vital parameters, Tracing reports

- Any fresh complaints, encircling abnormal findings, examination in inner Rooms
- Confirmation of whether patient is taking medication correctly or not has to be check.
- Appointment for follow up visit has to be given, Birth preparedness/ Encourage institutional delivery.
- High Risk Patient has to be admitted for initial evaluation immediately.
- Patient has to be advised regarding follow up visit date.
- Severe anaemia requiring blood transfusion – Admit.

WHO FANC model	**2016 WHO ANC model**
First trimester	
visit 1:1-12 weeks	Contact 1: up to 12 weeks
Second trimester	
visit 2:24-26 weeks	Contact 2: 20 weeks Contact 3: 26 weeks
Third trimester	
visit 3:-32 weeks visit 4:36-40 weeks	Contact 4: 30 weeks Contact 5: 34 weeks Contact 6: 36 weeks Contact 7: 38 weeks Contact 8: 40 weeks
Return for delivery at 41 weeks if not given birth.	

3.4 CHECK LIST FOR UNMARRIED PRIMIGRAVIDA

Unmarried Primigravida

- keep non judgmental and sensitive approch towards patient. Listen to complaints patiently as such patients may be reserved while telling history.
- Try to have atleast few minutes of conversation with patient in absence of relavies to give patient chance to express her concerns.Do not force into obtaining information.
- MLC in case of Minor(< 18 years).
- Patient has to be accompanied by a relative, preferably parents. Age proof has to be obtained.

In OPD

<20 WEEKS

- Patient has to be counselled.
- History has to be taken & examination has to be done.
- Social Worker reference has to be done. Advice has to be given to follow up in antenatal OPD
- If patient wants termination of pregnancy, requirement of MCTS/RCH number has to be fulfilled.
- Consent has to be taken (If < 18 years parent's/guardian's sign on consent).
- Admission has to be made in Gynaecward.

>20 WEEKS

- õ Counselling has to be done for continuation of pregnancy and history should be taken.
- õ Examination has to be done.
- õ Social Worker reference has to be done. Advice to follow up in antenatal OPD has to be given.

4. LABOUR ROOM PROTOCOL

4.1 GENERAL

- At 7:00 A.M.-reporting time for all residents on emergency duty :
- All patients who arrive before 7:00 A.M. seen by previous unit on duty will be handed over to next unit.
- All the residents from both units should be present at the time of handover of cases.
- Case files for history, examination finding, investigation reports and reqiured conset should be checked for completion before handing over the patient.
- FHS auscultation and PV examination will be done by final year resident.
- LR stock of BP apparatus, emergency drugs, light source at examination table, weighing scale,HIV KIT with buffer solution, alcohol-based hand wash, and Antiseptic solution has to be checked.
- LR stationary items like treatment sheets, carbon paper, MFTI tags and call book has to be checked.
- The availability of blood and blood products in blood bank has to be checked and mentioned on the notice board
- LR phone has to be checked and if not working, has to be informed to Sister-in-charge.
- The availability of Sexual assault examination kit has to be checked &survivor in Sexual Assault has to be examined in survivors room in ward.
- JR 1 should report in ward at 5.30 am on emergency days.
- Ward round on emergency days should be completed before 7:00 am. by JR 3.
- **Receiving room**
- No patient has to be kept waiting at 7:00 am from Previous emergency.
- The cleanliness of examination table has to be confirmed.
- Blood samples should not be kept pending on the table.
- No referral calls from other departments should be kept pending.
- The availability of delivery tray and speculum, examination tray, presence of CPCR tray with fully functioning items ,Weighing machine, HIV spot test kits and buffer has to be confirmed. There should be 7 trays as per norms.
- All birth records should be completed by 8 A.M.& should be signed by both JR3 & Assistant Professor. (Labour Room Stat proforma)
- Labour room register should be signed by Assistant Professor & on call Associate Professor of emergency unit daily at 9 am.

- No stock of drugs & consumables have to be confirmed from LR staff.
- Every women should be labelled according to maternal foetal triage index. (MFTI)

4.2 Guidelines for Infection prevention in Labour Room :

- A part of this guidelines (i.e. Criteria for minimum labour table) should be earmarked as septic labour tables.
- Slippers should to be used for entering the labour/pre-labour room.
- Labour Room should have demarcated area for keeping slippers for the hospital staff and relatives.
- Sterile gown should to be given to patient going for delivery.
- Floor should be cleaned as per defined GOI protocols.
- Proper sterilization has to be ensured for gloves, instruments, linen etc. needed for conducting a delivery. Standard procedures for disinfection and sterilization need to be followed as indicated in the guidelines.
- Sodium hypochlorite solution must be used to decontaminate the used gloves, instruments etc.
- After use the items should not be thrown on the floor or elsewhere.
- Disinfect the items as above and then autoclave. After following the steps of decontamination then proceed further with the next step for sterilization.
- Clean the floor and sinks with detergent (soapy water) and keep floor dry.
- Clean table top with Phenol/Hypochlorite solution.
- Clean other surfaces like light shades, almirahs, lockers, trolley, etc with low level disinfectant.
- Clean electronic monitors with 70% alcohol.
- In case of spillage of blood, body fluids on floor, absorb with newspaper (discard in yellow bin) soak with hypochlorite solution for 10 minutes and then mop.
- Discard placenta in yellow bins.
- Discard soiled linen in laundry basket and not on floor and then disinfect with hypochlorite solution followed by washing and autoclaving.
- Mop the floor every 3 hrs. with disinfectant solution.
- Clean the labour table after every delivery.
- Weekly fumigation should be carried out and record of the same should be kept
- Swab should be collected quarterly from LR and record of the same should be kept.

- Waste disposal – Colour-coded bins should be emptied at least once a day or as and when they are full.

4.3 After delivery :

- IPD paper for every neonate should be created and it should have baby notes with baby foot prints certified by attending staff nurse/ANM. Baby notes should be written

4.4 Newborn Care Corner :

- This is MANDATORY for all Labour rooms and obstetric OTs of 'delivery points'.
    - Essential care at birth
    - Resuscitation of newbor
    - Provision of warmth
    - Early initiation of breastfeeding
    - Weighing the neonate
    - Inspecting newborn for gross congenital anomalies
    - Every labour room and obstetric OT should have an NBCC, with a radiant warmer, a functional bag and mask of appropriate size, complete resuscitation kit and emergency tray.
    - Room should be draught free.
- Please note that every baby will not need care under a radiant warmer. Only when the following conditions are observed in the mother or baby, then the baby should be put under a radiant warmer for ENBC and, if required, resuscitation should be given.
    - Meconium stained liquor and preterm labour.
    - Baby not cried and limp/flaccid limbs/floppy baby.
    - Or as per doctor's advice.

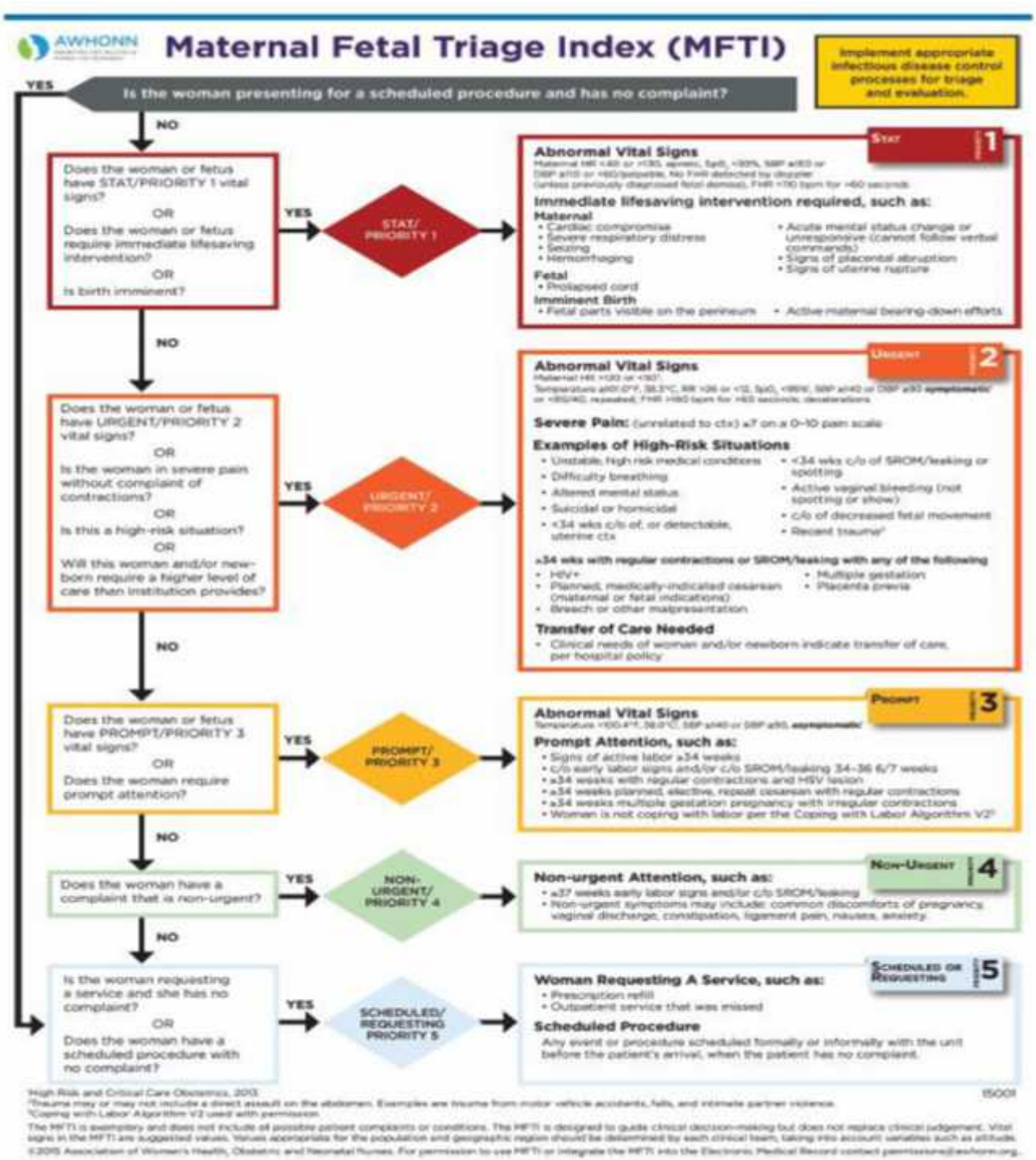
Do's and Don'ts for Labour room

Do	Don't
1. Equipment must be checked for its functionality during change in shifts of nursing staff.	1. Do not keep almirahs and metal cabinets in the LR. 2. Do not burn coal in LR.

2. Privacy and dignity of the woman to be ensured. 3. Use sterilized instruments for every delivery. 4. Each labour table must have a light source. 5. Use plastic curtains between tables. 6. LR should be draught free. 7. 20% buffer stock of LR drugs must be available all the time. 8. Temperature between 25-28 0 C must be maintained in LR. 9. Injection Oxytocin should be kept in fridge. 10. Practice infection prevention protocols. 11. Initiation of breast feeding within half an hour	3. Do not allow doctors/nurses and birth companion to enter LR without wearing gown, cap, slipper and mask. 4. Do not put cloth curtains between labour tables as they gather dust. 5. Do not allow people to enter labour room unnecessarily. 6. Do not put pressure on the abdomen for accelerating labour/delivery. 7. Do not give routine oxytocin IM or in drip for augmenting labour pains before delivery without indication. 8. Do not conduct frequent P/V examination. 9. Do not slap the baby if not crying. 10. Do not keep the baby unwrapped.

Do's and Don'ts for Newborn Care

Do	Don't
1. Always wash your hands before handling the baby. 2. Rooming in of baby with the mother. 3. Keep the baby warm. 4. Take extra care to maintain baby's temperature in preterm and LBW baby. 5. Keep the cord dry and clean. 6. Breast fed the baby exclusively. 7. Early initiation of breast feeding is essential for a good reflex action. 8. Any signs/ symptoms of complications must be referred and attended to by a doctor. 9. The care provider should observe every 2 hours in the first 6 hours and every 6 hours from 6 –24 hours after delivery.	1. Do not keep all babies as a routine under the radiant warmer. 2. Do not delay breast feeding beyond half an hour as that may lead to rapid decrease in suckling reflex of the baby. 3. Do not use prelacteals even water. 4. Do not apply anything on the cord. 5. Do not bathe the newborn for 24hrs after birth. 6. Do not forget to undertake routine Checkup.


AWHONN
Maternal Fetal Triage Index (MFTI)
Implement appropriate infectious disease control processes for triage and evaluation.
YES
Is the woman presenting for a scheduled procedure and has no complaint?
NO
Does the woman or fetus have STAT/PRIORITY 1 vital signs?
OR
Does the woman or fetus require immediate lifesaving intervention?
OR
Is birth imminent?
YES
STAT/ PRIORITY 1
Abnormal Vital Signs
Immediate lifesaving intervention required, such as:
Maternal
• Cardiac compromise
• Severe respiratory distress
• Seizing
• Hemorrhaging
• Acute mental status change or unresponsive (cannot follow verbal commands)
• Signs of placental abruption
• Signs of uterine rupture
Fetal
• Prolapsed cord
Imminent Birth
• Fetal parts visible on the perineum
• Active maternal bearing-down efforts
STAT 1
NO
Does the woman or fetus have URGENT/PRIORITY 2 vital signs?
OR
Is the woman in severe pain without complaint of contractions?
OR
Is this a high-risk situation?
OR
Will this woman and/or newborn require a higher level of care than institution provides?
YES
URGENT/ PRIORITY 2
Abnormal Vital Signs
Severe Pain: (unrelated to ctx) ≥7 on a 0–10 pain scale
Examples of High-Risk Situations
• Unstable, high risk medical conditions
• Difficulty breathing
• Altered mental status
• Suicidal or homicidal
• <34 wks c/o of, or detectable, uterine ctx
• <34 wks c/o of SROM/leaking or spotting
• Active vaginal bleeding (not spotting or show)
• c/o of decreased fetal movement
• Recent trauma
≥34 wks with regular contractions or SROM/leaking with any of the following
• HIV+
• Planned, medically-indicated cesarean (maternal or fetal indications)
• Breech or other malpresentation
• Multiple gestation
• Placenta previa
Transfer of Care Needed
• Clinical needs of woman and/or newborn indicate transfer of care, per hospital policy
URGENT 2
NO
Does the woman or fetus have PROMPT/PRIORITY 3 vital signs?
OR
Does the woman require prompt attention?
YES
PROMPT/ PRIORITY 3
Abnormal Vital Signs
Prompt Attention, such as:
• Signs of active labor ≥34 weeks
• c/o early labor signs and/or c/o SROM/leaking 34–36 6/7 weeks
• ≥34 weeks with regular contractions and HSV lesion
• ≥34 weeks planned, elective, repeat cesarean with regular contractions
• ≥34 weeks multiple gestation pregnancy with irregular contractions
• Woman is not coping with labor per the Coping with Labor Algorithm V2
PROMPT 3
NO
Does the woman have a complaint that is non-urgent?
YES
NON-URGENT/ PRIORITY 4
Non-urgent Attention, such as:
• ≥37 weeks early labor signs and/or c/o SROM/leaking
• Non-urgent symptoms may include: common discomforts of pregnancy, vaginal discharge, constipation, ligament pain, nausea, anxiety
NON-URGENT 4
NO
Is the woman requesting a service and she has no complaint?
OR
Does the woman have a scheduled procedure with no complaint?
YES
SCHEDULED/ REQUESTING PRIORITY 5
Woman Requesting A Service, such as:
• Prescription refill
• Outpatient service that was missed
Scheduled Procedure
Any event or procedure scheduled formally or informally with the unit before the patient's arrival, when the patient has no complaint.
SCHEDULED OR REQUESTING 5
High Risk and Critical Care Obstetrics, 2013.
[1]Trauma may or may not include a direct assault on the abdomen. Examples are trauma from motor vehicle accidents, falls, and intimate partner violence.
[2]Coping with Labor Algorithm V2 used with permission.
The MFTI is exemplary and does not include all possible patient complaints or conditions. The MFTI is designed to guide clinical decision-making but does not replace clinical judgement. Vital signs in the MFTI are suggested values. Values appropriate for the population and geographic region should be determined by each clinical team, taking into account variables such as altitude.
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15001

4.5 PROTOCOL FOR EXAMINATION OF A WOMAN IN LABOUR ROOM

1. Receive patient in Triaging Room
2. Consider that the patient requires emergency care and give stat treatment
3. Start with history taking by JR3/JR2. Ensure that the history taking and examination should be completely done by one resident.
4. Ensure to check all past records and identify any associated risk factors, known drug allergy.
5. Examine the patient and simultaneously write examination findings on RR sheet,write treatment orders and initiate treatment in emergency immediately
6. Triaging of patient should be done compulsorily in labour Room
7. Call for help whenever required
8. Take high risk consent/ consent for procedure if the decision of doing a procedure is taken in LR/Counselling
9. Inform all patients to Assistant Professor for senior findings
10. Insert Angiocath / Collect blood samples accordingly for each patient after the patient has been admitted.
11. Discuss and counsel the relatives regarding treatment & prognosis of patient.

For obstetric patients :

- Status has to be checked: Registered / Unregistered/Transferred Proper entry has to be made in referral list. Parent unit has to be checked.
- Patient has to be categorized like High risk / Low risk. Antenatal investigation reports have to be checked.
- Assistant Professor on call's findings in labour room have to be entered, in case of high risk patients.
- All high risk cases should be informed to Associate professor/ Professor on call.
- History has to be confirmed.
- History of previous LSCS, hypertension, thyroid disease & any other high risk factor has to be ruled out.
- Referral Letter if any, has to be noted.
- Treatment has to be started immediately.
- Progress of Labour has to be watched for.
- Maternal/ foetal parameter has to be monitored.
- Partograph has to be plotted especially in TOLAC, Pre-Eclampsia, Eclampsia and High risk Pregnancy.
- Oxytocin if used then oxytocin monitoring chart has to be prepared.
- Sterile precautions/waste disposal practices has to be followed according to standard guidelines.

- Counselling of Pt, for Labour Pain and progress.
- Relative counselled at the end of every station duty.
- Inductions have to be done on Labour Table.
- B.T. IV Fluids, Catheterisation (urine input output chart), Antibiotics, Mgso4, paperwork, consent has to be meticulously observed.
- Shifting of patient to labour table after cervix is 6-7 cm dilated.
- Delivery of patient should be conducted if fully dilated.
- Fundal pressure must not be applied to expedite the delivery process.
- Preparation for LSCS if indicated.

Labour Table :

- Labour has to be monitored.
- The beginning of second stage of labour has to be noted down.
- FHS and Maternal Parameters has to be monitored every 5 min. in 2nd stage in high risk cases.
- Monitoring chart should be prepared.
- I.V. line for IV Fluids & Oxytocics has to be maintained.
- Continuous assistance has to be given to the women with the help of assistant or
- interns/staff or class IV workers.
- Help of seniors, staff sister has to be taken.
- Plan & follow aseptic, Bio safety precaution for delivery.
- Positioning of head lamp.
- Preparation for assisted instrumental delivery & call Lecturer on floor if instrumental
- delivery is planned.
- Incase Episiotomy is needed then written consent has to be taken.
- Check availability of light, suction machine, sutures & other utilities for delivery.

4.6 PPH Prophylaxis

AMTSL

- Inj oxytocin 10 I.U I.M within 1 min of delivery. Delayed (1-3 minutes) cord clamping should be practiced. Cord clamping to be done earlier if baby requires immediate resuscitation.
- Rest of PPH management according to the protocol.
- Follow neonatal resuscitations as per norms.
- Episiotomy suturing without delay, No Handing over of episiotomy to other doctor for suturing. Catheterisation SOS.

- Maintain dignity& privacy of woman in Labour and counselling.
- Reporting of abnormal event e.g. continuous bleeding & drops/variation in FHR, non co-operative women immediately to JR3 & Asst. professor on floor.
- Stage IV observation in coordination with group.
- Paperwork has to be completed immediately after the delivery is completed
- Sex of the baby has to be shown to the mother by staff sister, attaching badge to baby and mother.
- High Alert for alarm to be initiated for sudden crisis of patient. e.g. PPH, collapse.

PNC Care, stage IV, shifting :

- Strict monitoring of mother for vitals & bleeding PV, Convulsions should be done.
- Neonatal observation, Breast feeding.
- MgSo4, antihypertensive, vit.k, O2, IV line, catheter, intake oral/ IV.
- Requirement of additional oxytocics.
- Any excessive bleeding p/v, pain or patients complaints.
- Record of Labour, stage IV monitoring chart.
- Counselling of patient & relatives
- Maintain dignity / privacy of women. Paperwork has to be completed.

4.7 * Eclampsia/Critical patient :

- Strict minute to minute monitoring.
- Pulse ox, Blood Pressure, Urine output, CTG monitoring.
- Every 10-15 min chart.
- Strict I/O charting.
- Dosage, MgSO4, Antihypertensive, Antibiotics.
- O2, IV line.
- Partograph.
- Inform to seniors.
- Counselling.
- Maintain dignity & privacy of women.
- Paperwork.

4.8 Postpartum IUCD (PPIUCD)

Timing of PPIUCD insertion

The correct timings of insertion are:

Postpartum :

- Post placental: Insertion within 10 minutes after expulsion of the placenta following a vaginal delivery, on the same delivery table
- Intracesarean: Insertion that takes place during a caesarean delivery, after removal of the placenta and before closure of the uterine incision.
- Within 48 hours after delivery: Insertion within 48 hours of delivery.
- Post abortion and post medical termination of pregnancy: Insertion following an abortion, if there is no infection, bleeding or any other contraindications.
- Extended Postpartum/Interval: Insertion any time after 6 weeks postpartum. Here the technique of insertion will be same as that of interval IUCD insertion

The IUCD should NOT be inserted from 48 hours to 6 weeks following delivery because there is an increased risk of infection and expulsion.

4.9 Schedule of Duties on post emergency days

- All JR I should be relieved at 6.30 a.m. for ward rounds on post emergency day.
- Between 6.30 a.m. to 7.30 a.m. one JR II should complete labour room statistics, one JR II should be at labour table conducting deliveries. JR III and assistant professor on call should be at waiting room, one JR II should be at receiving room.
- Between 8.15 a.m. to 10.15 a.m. assistant professor on call + JR III + all JR II should take all ward rounds. JR I should remain at his/her ward only.
- Between 11.00 a.m. to 12.00 p.m. unit incharge and associate professor should take ward round.
- Between 2.00 p.m. to 2.30 p.m. JR I should take his/her ward round.
- Between 3.00 p.m. to 4.15 p.m. PG activity should be conducted
- Between 4.15 p.m. to 5.00 p.m. unit incharge and assistant professor should take ward round
- At 8.00p.m. JR III should take only round for high risk patient.

4.10 POSTPARTUM HAEMORRHAGE (PPH)

Prepare, Prevent, Handle PPH

- Uterotonic agents (Oxytocin, Methyl ergometrine, Prostaglandins, Misoprostol, Tranexamic acid, carbetocin if available)should be available.
- Large bore IV cannula (no: 18), cava fix, IV fluids (Ringer lactate, normal saline and Hetastarch,Voluven) should be available. Blood of all blood groups and blood products should be available.
- Nature of PPH has to be determined (traumatic, atonic, or due to coaggulopathy). For traumatic PPH, instruments (Sims's speculum, AV retractor, 3 sponge holders, needle holders, forceps and light source, suture material) should be available. Venesection tray (2 mosquito forceps, scissors, plain forceps, tooth forceps, needle holder, scalpel with blade), glove balloon should be available.
- Sterile Gloves, sterile thread, Balloon Tamponade, (ex. ESM-UBT Balloon, bakri balloon as per availibility) and NASG garment.
- Any appropriate instruction has to be given sooner than later.
- Use of "Golden hour" i.e. patient should receive all modalities of treatment in these 2 hours period.
- Patient's counselling has to be done, relatives should be explained & written informed valid consent has to be taken.
- Aggressive management of massive PPH is a rule.

Algorithm for Management of Atonic PPH should be done as per the guidelines given in the algorithm below.

Sooner is better than latter - Principle works.

	CLASS I	CLASS II	CLASS III	CLASS IV
BloodLoss (ml) %	<750 15%	750-1500 15%-30%	1500-2000 30-40%	>2000 >40%
HR	<100	>100	>120	>140
BP	normal	normal	decrease	decrease
PP	normal	decrease	decrease	decrease
RR	14-20	20-30	30-40	>35
UOP	>30	20-30	5-15	negligible
CNS	slightly anxious	mildly anxious	anxious confused	confused lethargic

WHO recommendations for the prevention and treatment of postpartum haemorrhage

Box A: Recommendations for the prevention of PPH

1. The use of uterotonics for the prevention of PPH during the third stage of labour is recommended for all births. (Strong recommendation, moderate quality evidence)
2. Oxytocin (10 IU, IV/IM) is the recommended uterotonic drug for the prevention of PPH. (Strong recommendation, moderate-quality evidence)
3. In settings where oxytocin is unavailable, the use of other injectable uterotonics (if appropriate ergometrine/methylergometrine or the fixed drug combination of oxytocin and ergometrine) or oral misoprostol (600μg) is recommended. (Strong recommendation, moderate-quality evidence)
4. In settings where skilled birth attendants are not present and oxytocin is unavailable, the administration of misoprostol (600 μg PO) by community health care workers and lay health workers is recommended for the prevention of PPH. (Strong recommendation, moderate-quality evidence)
5. In settings where skilled birth attendants are available, CCT is recommended for vaginal births if the care provider and the parturient woman regard a small reduction in blood loss and a small reduction in the duration of the third stage of labour as important (Weak recommendation, high-quality evidence)
6. In settings where skilled birth attendants are unavailable, CCT is not recommended. (Strong recommendation, moderate-quality evidence)
7. Late cord clamping (performed after 1 to 3 minutes after birth) is recommended for all births while initiating simultaneous essential newborn care. (Strong recommendation, moderate-quality evidence)
8. Early cord clamping (<1 minute after birth) is not recommended unless the neonate is asphyxiated and needs to be moved immediately for resuscitation. (Strong recommendation, moderate-quality evidence)
9. Sustained uterine massage is not recommended as an intervention to prevent PPH in women who have received prophylactic oxytocin. (Weak recommendation, low-quality evidence)
10. Postpartum abdominal uterine tonus assessment for early identification of uterine atony is recommended for all women. (Strong recommendation, very-low-quality evidence)
11. Oxytocin (IV or IM) is the recommended uterotonic drug for the prevention of PPH in caesarean section. (Strong recommendation, moderate-quality evidence)
12. Controlled cord traction is the recommended method for removal of the placenta in caesarean section. (Strong recommendation, moderate-quality evidence)

Box B: Recommendations for the treatment of PPH

13. Intravenous oxytocin alone is the recommended uterotonic drug for the treatment of PPH. (Strong recommendation, moderate-quality evidence)
14. If intravenous oxytocin is unavailable, or if the bleeding does not respond to oxytocin, the use of intravenous ergometrine, oxytocin-ergometrine fixed dose, or a prostaglandin drug (including sublingual misoprostol, 800 µg) is recommended. (Strong recommendation, low-quality evidence)
15. The use of isotonic crystalloids is recommended in preference to the use of colloids for the initial intravenous fluid resuscitation of women with PPH. (Strong recommendation, low-quality evidence)
16. The use of tranexamic acid is recommended for the treatment of PPH if oxytocin and other uterotonics fail to stop bleeding or if it is thought that the bleeding may be partly due to trauma. (Weak recommendation,moderate-quality evidence)
17. Uterine massage is recommended for the treatment of PPH. (Strong recommendation, very-low-quality evidence)
18. If women do not respond to treatment using uterotonics, or if uterotonics are unavailable, the use of intrauterine balloon tamponade is recommended for the treatment of PPH due to uterine atony. (Weak recommendation, very-low-quality evidence)
19. If other measures have failed and if the necessary resources are available, the use of uterine artery embolization is recommended as a treatment for PPH due to uterine atony. (Weak recommendation, very-low quality evidence)
20. If bleeding does not stop in spite of treatment using uterotonics and other available conservative interventions (e.g. uterine massage, balloon tamponade), the use of surgical interventions is recommended. (Strong recommendation, very-low-quality evidence)
21. The use of bimanual uterine compression is recommended as a temporizing measure until appropriate care is available for the treatment of PPH due to uterine atony after vaginal delivery. (Weak recommendation, very-low quality evidence)
22. The use of external aortic compression for the treatment of PPH due to uterine atony after vaginal birth is recommended as a temporizing measure until appropriate care is available. (Weak recommendation, very-low-quality evidence)
23. The use of non-pneumatic anti-shock garments is recommended as a temporizing measure until appropriate care is available. (Weak recommendation, low-quality evidence)
24. The use of uterine packing is not recommended for the treatment of PPH due to uterine atony after vaginal birth. (Weak recommendation, very-low quality evidence)
25. If the placenta is not expelled spontaneously, the use of IV/IM oxytocin (10 IU) in combination with controlled cord traction is recommended. (Weak recommendation, very-low-quality evidence)

26. The use of ergometrine for the management of retained placenta is not recommended as this may cause tetanic uterine contractions which may delay the expulsion of the placenta. (Weak recommendation, very-low quality evidence)
27. The use of prostaglandin E2 alpha (dinoprostone or sulprostone) for the management of retained placenta is not recommended. (Weak recommendation, very-low-quality evidence)
28. A single dose of antibiotics (ampicillin or first-generation cephalosporin) is recommended if manual removal of the placenta is practised. (Weak recommendation, very-low-quality evidence)

Box C: Organization of care

29. The use of formal protocols by health facilities for the prevention and treatment of PPH is recommended. (Weak recommendation, moderate quality evidence)
30. The use of formal protocols for referral of women to a higher level of care is recommended for health facilities. (Weak recommendation, very-low quality evidence)
31. The use of simulations of PPH treatment is recommended for pre-service and in-service training programmes. (Weak recommendation, very-low-quality evidence)
32. Monitoring the use of uterotonics after birth for the prevention of PPH is recommended as a process indicator for programmatic evaluation. (Weak recommendation, very-low-quality evidence)

Postpartum Hemorrhage After Vaginal Delivery[1]

[1] WHO: Persistent bleeding:
EBL > 500 ml after vaginal delivery
EBL > 1000 ml after caesarean section

Obstetric Team | **Anesthesia Team**

OBS

Obstetric assessment
- tone (uterotonic agents)
- trauma (inspect birth canal, exclude uterine rupture)
- retained placenta (sonography)

TXA 1 g in 100 ml NaCl i.v. (10 min)

Oxytocin 5 IU i.v., then 10-20 IU/2h infusion
and/or
Misoprostol 1000 µg rectally

Methyl ergometrine 0.2 mg i.m. or i.v.

Sulprostone 100-500 µg/h i.v. infusion

Emergency Call for Anesthesia Team

Tel 181 5912

Take baseline labs:
Hb, PLTs, PT/INR, aPTT, Fbg, TT, FXIII, ROTEM

Call Code PPH
Tel 2-3307
order 4 RBCs, 4 FFP, 1PLT, 2g Fibrinogen, rFVIIa

O_2 10-15 l/min per reservoir FM, large IV lines
set up LEVEL1 and autotransfusion device

- Warmed Ringer´s and HES 6% (20ml/kg max.)
- TXA 1g i.v. (10 min) if not yet given
- 2 units RBC O neg as required

Early stage, stable hemodynamics: Consider uterine artery embolisation (interventional radiology)

Uterine massage
Bimanual uterine compression
External aortic compression

Decision support for transfer to OR:
Heart Rate > 100/min
(consider relative bradycardia in beta blocked, athlete, pacemaker)

OR

O
R

RSI – Intubation
Level 1,
Radial arterial line

Oxytocin 10-20 IU/2h infusion
Sulprostone 100-500 µg/h infusion

Target:
- MAP 50 mmHg, pH > 7.2
- Hb > 85 g/L, Temp > 35°C
- PLTs > 50 G/L

- 4 RBCs, 4 FFP, 1 PLT
- Consider 1g Ca gluconate
- Fibrinogen 2g iv if Fbg <1g/L
- if bleeding continues after 4 RBCs and 4 FFP: 1st dose rFVIIa 60 µg/kg i.v

Curettage
Surgical repair of genital tract trauma
Uterine tamponade: surgical or by balloon catheter (optional)

Persistent bleeding
after 4-6 RBCs, 4 FFP, 1PLT, tamponade & values within target

If hemodynamically stable, consider uterine artery embolisation

Laparotomy
Compression sutures
Ligation uterine arteries or internal iliac artery

Order 2nd round of Code PPH
Tel 2-3307
Repeat labs: PT, aPTT, Fbg, TT, ROTEM, Hb, BGA, Ca^{++}

- Fibrinogen 2 g i.v. if Fbg <1g/L
- 4 RBCs, 4 FFP, 1 PLT, Ca^{++}
- 2nd dose rFVIIa 60 µg/kg i.v.

Persistent bleeding

Emergency Hysterectomy

Continue normovolemic transfusion, target:
- PLTs > 50 G/L
- Fbg > 1 g/L
- MAP 50 mmHg, pH > 7.2

- repeat 2g Fibrinogen i.v.
- consult hematology 181-6220 for:
  – FXIII 1250 IU i.v.
  – 3rd dose rFVIIa 60 µg/kg i.v.

PPH During Cesarean Delivery[1] (Expected)

Placenta previa, accreta, increta or percreta and/or uterine myoma

Individualized surgical and anesthesiologic management should be planned and documented preoperatively with the patient.

[1] WHO: Persistent bleeding.
EBL > 500 ml after vaginal delivery
EBL > 1000 ml after caesarean section

	Obstetric Team	Anesthesia Team	
OBS	**Baseline labs**: Hb, PLTs, PT/INR, aPTT, Fbg, TT, FXIII, ROTEM	O_2 10-15 l/min per reservoir FM, large IV lines, arterial line, LEVEL1, autotransfusion device	**Volume replacement Blood product transfusion**
		RSI (consider converting SSS)	
OR	Intraoperative autotransfusion	Carbetocin 100 µg i.v. (not in pre-eclampsia/eclampsia)	
	Cesarean Section	Oxytocin 10-20 IU (infusion)	
		Consider Misoprostol 1000 µg (rectally)	
		Sulprostone 100-500 µg/ h i.v. (infusion pump)	
		Methyl ergometrine 0.2 mg i.v. (not in HTN, pre-eclampsia)	
	PPH		- HES 6% (130/0.4) max. 20ml/kg - TXA 1 g i.v. (10 min) - 4 RBCs (from OR blood refrigerator)
	Compression sutures, vascular ligatures	**Call 2-3307 Code PPH, order** 4 units RBCs, 4 FFP, 1 PLT, 2g Fibrinogen, rFVIIa 60 µg/kg **Send coag labs:** PT, aPTT, Fbg, TT, FXIII, ROTEM	
	Persistent bleeding	**Target:** • MAP 50mmHg, pH > 7.2 • Hb > 85 g/L, Temp > 35°C • PLTs > 50 G/L	- 4 RBCs, 4 FFP, 1 PLT - Consider 1 g Ca gluconate - Fibrinogen 2g i.v. if Fbg <1g/L - if bleeding continues after 4 RBCs and 4 FFP: 1st dose rFVIIa 60 µg/kg i.v
	If hemodynamically stable, consider uterine artery embolisation (interventional radiology)		
	Persistent bleeding after 4-6 RBCs / 4 FFP / 1 PLT	**Order 2nd round of Code PPH** **Repeat labs:** PT, aPTT, Fbg, TT, ROTEM, Hb, BGA, Ca++	- Fibrinogen 2 g i.v. if Fbg <1g/L - 4 RBCs, 4 FFP, 1 PLT, Ca++ - 2nd dose rFVIIa 60 µg/kg i.v.
	Persistent bleeding despite continued transfusion	**Order 3rd round of Code PPH** **Repeat labs:** PT, aPTT, Fbg, TT, ROTEM, Hb, BGA, Ca++	- repeat 2g Fibrinogen i.v. - consult hematology 181-6220 for: – FXIII 1250 IU i.v. – 3rd dose rFVIIa 60 µg/kg i.v.
	Persistent bleeding	**Continue normovolemic transfusion, target:** • PLTs > 50 G/L • Fbg > 1 g/L • MAP 50 mmHg, pH > 7.2	
	Emergency Hysterectomy	RULE: repeat laboratory 15-30 min after each hemostatic intervention	

Management of PPH

- Shout for Help, RIA - evaluate vital signs: PR, BP, RR & Temp
- Establish two I.V. lines with wide bore cannulae (16-18 gauge)
- Draw blood for grouping & cross matching
- If heavy bleeding P/V, infuse NS/RL 1L in 15-20 minutes
- Give O2 @ 6-8 L / min by mask, Catheterize
- Check vitals & blood loss every 15 min, Monitor input & output

4.11 EMERGENCY ALARM FOR CRITICALLY ILL PATIENT AND SUDDEN COLLAPSE

- If any patient is critical, serious, sudden collapse or deviation from normal course of disease is present, then that patient must be informed (ALERT CALL) to the following seniors on duty.
- (RING THE ALARM)
    1) On call Lecturer No. 2 and No. 3.
    2) On call Associate Professor on duty and next Associate Professor on call.
    3) Unit In charge.
- For all practical purposes, all doctors in the unit must be informed and everyone as team should work to save mother's life. For serious patients there is no criteria of on or off call in emergency unit.
- The charge of critical patient has to be taken by the senior.
- All faculties posted in the unit must be alerted irrespective of on call or not.
- All must rush to serious patient of respective unit. Surgery if required should be performed by seniors.
- Second Asso. Professor has to look after emergency drugs, blood transfusion arrangement,relatives counselling, consent & paper work.
- All other outside calls and labour room management of rest of the patients has to be done by Asso. Professors - No. 2, Lecturer - No. 2, Lecturer -No. 3 in order, as per unit availability of faculty.
- Other work & patient management should be simultaneously continued as per norms.
- Under any circumstances other patients should not be neglected.
- If needed, unit on emergency should ask for help from other units.
- The relatives have to be counselled from time to time, and written, valid, informed consent about the explanation of disease prognosis should be obtained.
- Agitated relatives should be calmed down, involve seniors, if required.
- During resuscitation, privacy and dignity of the woman should be maintained.
- If male doctors are present, involve female co-residents, female doctors or staff nurses in the treatment.

CARDIOPULMONARY RESUSCITATION

- Responsibilities on your emergency day (by JR3):
- The presence of the resuscitation trolley/tray in every ward has to be checked.

- On-duty staff and doctors should be familiar with the location and contents of the resuscitation tray/trolley.
- The contents of resuscitation tray/trolley have to be checked routinely by the staff and on-duty JR3 at the time of emergency hand-over.
- The resuscitation tray/trolley has to be restocked and checked after use.
- Quality Assurance Criteria has to be met like: Asepsis.
- Contents should be correct as per the content list.
- All equipments should be functional and should be ready for use.
- The stock has to be within expiry date. (for medicines- first week of the month)
- The area staff member incharge / nursing sister incharge has to be informed if CPCR trays are unavailable or deficient.
- The presence of all required equipments needed for maintaining a patent airway has to be confirmed, such as-Pocket mask/ Hudson mask, oxygen port, AMBU bag, oxygen reservoir and tubing, Oropharyngeal airways- size 2,3,4, Endo-tracheal suction catheters, Portex Endotracheal tube – oral, cuffed size 6, 6.5, 7, with stellate. Bite block Laryngoscope- curved blades no. 3, 4, Spare laryngoscope batteries and bulbs. Filled Oxygen cylinder (if wall oxygen not available) Adhesive stretchable sticking plaster.
- Those trained in intubation should be immediately called for help.
- Working suction machine (if central suction is not functional) should be present. The presence of all required equipments needed for maintaining circulation has to be confirmed, such as-
- Intravenous catheters-14, 18, 20 G Hypodermic needles- 20, 21 G, Spirit swabs, Syringes- 2 ml, 5ml, 10 ml, 20 ml, Central venous line kit, Intravenous fluids- Ringer Lactate, Glucose 5%, 25%,Dextrose normal saline, Normal Saline, Intravenous infusion sets and Blood transfusion sets.Other drugs to be kept ready- Dopamine, Noradrenaline, Heparin, Pheniramine, Labetolol,Furosemide, Nitroglycerine.
- Immediate access to the following equipment has to be confirmed.
    - Stethoscope
    - Cardiac Monitor
    - Defibrillator
    - Bougie, LMA (Size 3)- 2
    - Bains circuit
    - Nebulizer
    - Cardiac Board

- Wedge
- Sphygmomanometer -Digital/Manual
- Digital Pulse oxymeter
- Head lamp
- ECG leads
- Gloves
- Torch
- During Emergency Help is called.

4.12 INSTRUMENTAL DELIVERY

Vacuum Delivery :

- Indication for Vacuum delivery has to be present. Contraindications for Vacuum delivery have to be ruled out. Prerequisites for Vacuum delivery have to be maintained. Decision has to be made by Assistant Professor on duty. Assistant Professor has to be present during the procedure.
- Written, informed and valid consent has to be obtained.
- Required additional personnel should be available. Neonatologist ,Nurse, Supporting Staff should be available.
- Autoclaved proper size cup, rubber tubing and working suction machine has to be used.
- Urinary bladder and rectum has to be emptied.
- Aseptic and antiseptic precautions have to be used by obstetrician.
- After the procedure, complications like extension of the episiotomy; lacerations in the vulva, vagina and cervix have to be looked for.Cervical tracing (exploration) has to be done.
- Any extensive suturing has to be done in Operation Theatre under Anaesthesia.

Obstetric Forceps Application :

- Indication for obstetric forceps delivery has to be present. Contraindications for obstetric forceps delivery have to be ruled out. Prerequisites for obstetric forceps delivery have to be met.

- Decision has to be made by Assistant Professor on duty. Assistant Professor has to be present during the procedure.
- Written, informed and valid consent has to be obtained.
- Required additional personnel should be available. Neonatologist / paediatric resident, Nurse, Servant should be available.
- Proper size forceps are available (short), autoclaved within previous 24 hours.
- Both the blades should be of the same forceps.
- Both the blades should be locked by doing phantom application of the forceps.
- Urinary bladder and rectum has to be emptied.
- Aseptic and antiseptic precautions have to be used by obstetrician. After the procedure,
  complications like extension of the episiotomy; lacerations in the vulva, vagina and cervix should be looked for. Cervical tracing has to be done.
- Availability of blood & requirement has to be assessed.

Baby Notes :

- After delivery of baby check Apgar score , weight and sex of baby, congenital anomaly if any.
- CRN call has to be written for neonatal examination

4.13 HANDING OVER TO OTHER UNIT IN LABOUR ROOM

- Patients over should be handed over at 7.30 am by JR-III & Assistant Professor.
- As far as possible handing over of patient will be after good management according to protocols and guidelines.
- No patient should be handed over without proper treatment.
- Second stage arrest, foetal distress, APH, Critically ill patient requiring LSCS should not be given in over to other unit.
- If due to heavy workload or short of hands or any seriously ill patient above mentioned patient can be given in over at Assistant Professor and HOU level.
- All Present Relatives of the women should be counselled regarding further progress of labour or her clinical condition.
- There should be smooth interaction between two units in front of woman in labour.
- Her Hb% , required investigations shall be traced and handed over in detail regarding treatment given and proposed to women in labour.
- Complete checklist of woman regarding risk assessment to be done.
- External calls and prescription has to be handed over.

5. INPATIENT WORKPROCESS

5.1 ANTENATAL WARD

- After admission, counselling of the patient &relatives has to be done and written
- Informed consent regarding prognosis of patient has to be obtained.
- At 6:00 A.M.(Ward Looker)
- For New admissions / trans-in patients from Labour ward following things have to be checked.
- Consent for treatment has to be taken by Staff.
- The patient has to be allotted a bed belonging to respective unit, whenever available.
- Weight, height and urine albumin has to be recorded if required. Clipping of private parts has to be done as and when required.
- For each admitted/trans-in patient admission / transfer has to be taken by staff.
- History & Examination.
- Hb, urine routine Blood grouping & Rh typing, VDRL, HIV, FBS/PLBS TSH, HBsAg and USG (Obs routine, malformation scan)reports have to be checked..
- Immunization status has to be checked and High risk counselling has to be done. Seniors have to be informed as per requirement.
- Findings of qualified doctor and all necessary details have to be noted on case paper.
- Orders to be carried out by staff have to be written on case paper.
- For blood and body fluid investigations : All investigations during routine hours have to be sent before 10 am.
- For urine routine, the following have to be checked (Clean container, Clean catch sample) In catheterized patient , sample collection has to be done from Foley's catheter.

On rounds :

- Pulse, Blood pressure & FHS have to be checked every 12 hrly.(more frequently if needed)
- In selected patients, daily foetal kick count/Cardiff count has to be asked.

- In case of any deviation from normal findings in examination/investigation, seniors have to be informed immediately.
- If anything is not working properly, on duty Staff has to be informed.
- Low risk patients and Patients who are not in labour, in such cases blood investigations & USG. can be done at ANC clinics.
- If a patient has to be transferred to labour ward : Fresh orders have to be written.
- Clipping of her private parts has to be rechecked.
- The patient has to be shifted on a wheelchair or trolley as per requirement by servant accompanied by her relative.
- Transfer entry with date and time has to be made in admission book (by staff) as well as in indoor paper (by doctor) & HMIS.
- On duty residents have to be informed and if patient is critical, Assistant Professor or HOU has to be informed.

For elective induction of labour :

- Pre-induction orders have to be written by doctor which have to be carried out by staff nurse. Consent has to be duly signed by patient, relative and witness.
- Prescription has to be given in MCI format.
- The details of the patient to be shifted to the labour ward has to be written on the indoor paper.
- Seniors have to be informed.
- Induction has to be done in Labour Room only.

For elective procedures, check :

- Preoperative investigations have to be done and anaesthesia fitness has to be obtained.
- Sticker of patient's name, MRD number and unit has to be labelled by the staff
- Preparation of surgical parts and scrubbing has to be done in ANC ward .
- Senior doctor's findings and decision for the procedure have to be confirmed.
- Written informed valid consent with date & time has to be taken.
- Relatives should be present before any Elective Procedure.

One day prior to surgery :

- OT list has to be given to the Anaesthetist and OT Sister incharge before 1:00 P.M.

- Routine Blood Grouping and Cross Matching has to be sent.
- Anaesthesia fitness should be checked &preoperative orders have to be written.
- Medications/ consumables not available in the hospital or which cannot be arranged by the hospital have to be prescribed in MCI prescription format.
- Availability of blood has to be checked and blood has to be reserved.
- Operation list of posted patients has to be given to the Staff nurse of the respective ward.

On the day of surgery :

- All the preoperative orders whether carried out or not ,have to be confirmed.
- Written informed valid consent has to be taken.
- Confirm that patient has taken bath and wore OT gown which has been labelled with a label mentioning name, MRD number, and unit along with procedure
- Confirm that surgical parts have been prepared.
- The availability of relatives with the patient has to be confirmed.
- A Cap has to be given to cover the patient's hair.
- The patient has to be shifted on a trolley or wheelchair, as per requirement, with servant accompanied by relatives and Houseman on call.

5.2 PNC WARD

- Proper patient monitoring has to be done.
- Perineal care has to be given to all patients who has delivered.
- All post delivery notes have to be written.
- Orders of the following have to be written:
  -Inj. Vitamin K - Inj. Vitamin K (Phytonadione) 1mg i.m. for baby more than 1 kg.
  -Inj. Vitamin K - Inj. Vitamin K (Phytonadione) 0.5 mg i.m. for baby less than 1 kg.
  -Initiate Breast Feeding within half hour of delivery.
- All Birth Book Certificates and required forms have to be filled.
- Shifting notes in low risk patients have to be written after 2 hours of delivery i.e after patient's stability &no active bleeding PV has been confirmed. Shifting notes in high risk patients have to be written after 6 hours or after stabilization of General condition.
- Delivered patients monitoring -

◦ For High risk patients-every 15 mins x 2 hours, every 30 minsx next 2 hours, 2 hourly x next 4 hours.2 hourly Assistant Professor rounds.

◦ For Low risk patients monitoring-Every 15 minutes x1 hour, every 30 mins x next 1 hour.

• Patients have to be shifted on a wheelchair/trolley from labour room to PNC room. All beds have to be cleaned by supporting staff after delivery.

• Still birth babies should be handed over to relatives after 1 to 2 hrs depending on availability of relatives. if relatives are not ready to take dead body due to some technical problem it will be handed over after there convenience.

• All on call Assistant Professor should confirm FSB/Maternal morbidity and any other communication, behavioural problem.

• All FSB and complications should be immediately informed to all concerned seniors. Relative should be informed and counselled for consent.

• CR Neonatology call is not required for IUFD / Still Births.

• All Instrumental deliveries and High Risk babies must be seen by CR Neonatology.

• Sex of the baby has to be confirmed by JR3/JR2, sisters &mother.

• Women should receive her medication in PNC room.

• Establishment of breast feeding should be started within half an hour after delivery.

• It's joint responsibility of doctors & on duty staff to monitor patient in PNC room.

• IV fluids / oral sips / tea coffee is allowed after delivery depending on condition of patient.

• All PNC patients should be monitored as per PNC Monitoring Chart.

COUNSELLING ABOUT CONTRACEPTION :

• Counselling about exclusive breast feeding has to be done.

• PNC P1L1 has to be counselled regarding spacing methods of contraception for first 6 months of period.

• Cafeteria approach with WHO Medical Eligibility Criteria (MEC) should be opted for all delivered patients.

• Multigravida patients have to be counselled for option of permanent methods of contraception like tubal ligation which can be performed after 24 hours of hospital delivery, after 1 and half month. Or for her husband's vasectomy.

• Women should be explained about advantages and disadvantages of methods and freedom should be given to her to select the method of contraception without any coercion or force.

5.3 GYNAECOLOGY WARD

- After admission, counselling of the patient & relatives should be done and written informed consent regarding prognosis of patient has to be taken.

For each patient :

- Admission history has to be taken and examination has to be done by JR and CR before 4 pm on the same day and urgently in case of emergency.
- Clipping has to be done by nurse.
- Proper bed allotment has to be done as per unit, whenever available. Hospital dress has to be given.
- Investigations : CXR, ECG, USG, all routine blood and urine investigation & If required 2D ECHO,TSH, Electrolytes should be done.
- For patients posted for surgery, check whether findings of senior doctor and decision for the procedure has to be entered on the case paper.
- Preoperative investigations have to be done. Anaesthesia fitness has to be obtained. Mahatma Phule Jeevandayee Arogya Yojana status has to be checked.
- Blood donation has to be arranged, if posted for major surgery. Written informed consent has to be obtained.
- Preoperative chart has to be prepared.

On the day of surgery :

- Preoperative orders have to be carried out. It has to be confirmed that the patient has taken bath, changed clothes, passed stools, and clipping has been done.
- A label has to be put on the patient's gown mentioning name, MRD no. Unit& procedure. It has to be confirmed that relatives should be present with the patient.
- Cap has to be given to cover the patient's hair.
- All investigation reports have to be given back to the patient's relatives after procedure.

- **Emergency surgery :**
- Call has to be sent to on call anaesthesia team from Labour room or Ward.
- Check whether patient has been seen by anaesthetist before being taken on OT table.
- Check whether all essential investigations have been done.
- PT-INR in selected cases such as eclampsia/pre-eclampsia, intra-uterine foetal demise, liver disorders, patients on anticoagulation etc. after written consent from relatives have to be sent.
- If anticoagulation is not stopped prior as in emergency surgery, blood and blood products' (fresh frozen plasma, cryoprecipitate and platelet concentrate) availability has to be confirmed.
- Epidural anaesthesia :
  In case of epidural anaesthesia, check that post operative top up has been given.
- On 2nd postoperative day, check that catheter has been removed by OT anaesthetist.

Post Operative Monitoring Of Gynaecological Patients – Day 1 :

- The wound has to be dressed and sterile pad has to be applied to vulva.
- It has to be checked whether patient has given appropriate position- Trendelenburg, propped up or supine.
- It has to be checked that anaesthesia paper is attached and intra-operative input/output, blood loss are charted.
- If anaesthetist has mentioned references/investigations, it has to be done
- It has to be checked if Foley's catheter is strapped to the thigh in traction-free manner.
- It has to be checked if patient has adequate intravenous hydration. It has to be checked that orders are being followed by ward staff.
- If the patient has a drain/Ryle's tube in-situ, it has to be checked whether it is fixed properly and its output has been charted.
- It has to be checked that a measuring tape is kept to measure abdominal girth.
- It has to be checked that vitals are monitored regularly. If patient is diabetic, it has to be checked that IV fluids having dextrose should not to be infused.
- Post-operative monitoring: half hourly for first 2 hours, hourly for next 4 hours, 2 hourly up to 24 hours Check for vital parameters, per abdomen and per vaginal bleeding.

- Monitoring Chart should include Time, Pulse Rate, Blood Pressure, SPO2 saturation, Urine Output, Drain output, Abdominal Girth & Bleeding PV.
- Resuscitate and simultaneously inform to Seniors if:
  ? Pulse <60 or >100/min
  ? Blood pressure < 90/60 or > 140/90 mm Hg, urine output <60 ml/2 hours
  ? Abdominal girth > 3cm/hour, excessive vaginal bleeding
- BSL (2 hourly) especially if the patient is on neutralizing insulin drip, urine sugars/ketones (1 hourly).
- Insulin infusion if required, it has to be titrated as per target blood glucose levels and adjustment suggested by physician / Gynaecologist / Anaesthesiologist.
- It has to be checked that all medications which the patient was taking for any medical condition are administered via appropriate route unless specifically omitted.
- It has to be checked that timing of antibiotic administration is mentioned.

Post-operative ward :

- Check whether the patient has been shifted to the bed and post-operative orders have been carried out.
- The patient has to be asked to remain nil by mouth.
- Vital parameters have to be checked regularly: temperature, pulse, blood pressure, urine output(volume, clear /concentrated/ haematuria) Per abdominal examination has to be done
- Uterus (well contracted or not) Guarding, rigidity, tenderness and dressing (dry or soaked) has to be checked
- Abdominal girth.Vulval pad has to be checked for haemorrhage.
- **Post-operative - Day 2 :**
- Vital parameters, per abdomen and per vaginal bleeding has to be checked.
- Fluid input and output, Dressing (dry or soaked) and peristaltic sounds have to be checked.
- Oral sips of water should be given if peristalsis is present. Tolerance of oral water has to be checked. IV fluids as per requirement has to be given.
- It has to be checked that patient takes small sips initially and is gradually shifted to soft diet followed by full diet.
- The patient has to be ambulated early. Foley's catheter has to be removed.

- It has to be noted whether the patient has passed urine subsequently.
- It has to be checked that a sample for urine analysis has been sent on day 3. It has to be checked that catheter should be kept in situ in following cases-Anterior colporrhaphy: 2 days, Bladder injury: longer if required.
- It has to be checked that drain is not blocked.
- Those patients undergone vaginal procedure having perineal sutures, antiseptic cream for local application should be checked.

Post-operative - Day 3 :

- Soft diet has to be given. Full diet has to be given if soft diet is tolerated.
- Urine has to be sent for urine analysis and blood has to be sent for haemoglobin estimation
  according to unit protocol.
- Required investigations have to be done and references have to be made for associated comorbidities.
- **Post-operative – Day 5 :**
- Wound has to be checked (healthy or not) as per protocol. Sometimes check dressing has to be done on day 5 or earlier if there is wound soakage.
- If wound is healthy & patient is residing near by and ready to come immediately after any emergency then only she should be discharged, otherwise discharge on 8th day.
- If unhealthy -wound swab has to be sent for microbiology study. Wound dressing has to be done every day.
- Antibiotic has to be changed according to culture sensitivity report. Secondary suturing has to be done when the wound is healthy. The patient has to be discharged after suture removal.

On discharge :

- Discharge card has to be given: all necessory medication and followup should be mentioned and explained to patient and relative.

6. WRITING CALLS TO DIFFERENT DEPARTMENTS

- The calls must be addressed properly, with words including “please”, “please may I ask you” like words.
- Diagnosis, present condition of the patient and the reason for sending the call to that faculty should be clearly mentioned.
- In case of busy schedule call can also be communicated on phone/SMS/WhatsApp (If online).
- Seniors' call can be informed to CR for communication.
- If call is not attended in specified time, then report the unit/ faculty to CMO/RMO for urgency of call and required further action.
- Mention call on paper with date and time.
- If call is written as routine then wait for 12 hours, if it is written on an urgent basis then must be attended in an hour except for anaesthesia call (here immediate help is sought).

Protocol for writing a call to another department

Date: _____

Patient's Name:_____

MRD No. _____ WARD NO.-------

Time: _____

To,

CR/Asst. Prof./ Asso. Prof./ HOU/

Speciality, Unit (On call/Specific Unit)

Nature of call- Routine/Urgent/Follow-up (Review)/ Transfer

Please call over to WD/OT _____ to examine this patient of

Diagnosis _____

for your expert opinion and further management.

At present her GC ____ PR ____ BP ____ Urine Output _____ BUN _____ BSL _____

(any other significant finding),

needs your expert opinion.

Thanks

Yours sincerely,

Signature of Doctor

7. PROTOCOL FOR TRANSFER OF PATIENT

7.1 FROM GYNAECOLOGY DEPARTMENT TO OTHER DEPARTMENT

- Unit In charge has to affirm that the patient is in condition to be transferred to other department.
- Availability of ambulance has to be checked before and patient must not be mobilised from ward unless ambulance is waiting near the casualty.
- Written, informed and valid consent has to be taken from patient and her relatives, mentioning the reason for transfer of patient to another department.
- Concerned unit doctors and ward staff (where patient is going to be transferred) has to be informed before transfer of patient.
- Critically ill patient has to be transferred with accompanied resident doctor.
- Concerned unit to whom patient primarily belongs, has to attend the patient twice a day wherever the patient is transferred or as and when required as per patient's condition.
- Daily follow-up of transferred patient has to be given to the Unit In charge of concerned unit.

7.2 FROM OTHER DEPARTMENT TO GYNAECOLOGY DEPARTMENT

- The indoor paper of the patient has to be made available.
- A call, in writing, has to be sent and noted by gynaecologist for evaluation and transfer of the patient to gynaecology department.
- The patient has to be evaluated by the CR/ staff member.
- If the transfer is required, then the patient's detailed status has to be informed to the Head of Unit.
- Transfer entry has to be made on the transfer column on the front page of the indoor case sheet by CR and duly signed with date and time. The staff nurses on duty of both the wards have to b e informed regarding the transfer.
- The patient has to be transferred on a wheel chair or trolley depending on the patient's condition and has to be accompanied by a doctor/nurse.
- The transfer summary and specific treatment orders have been written by the respective transferring doctors.
- Unit and ward change has been done on front page of indoor case sheet by the registration department.
- The transfer has been duly noted by the staff nurse.
- Subsequent management will be as per check list for new admission.

8. DISCHARGE SUMMARY

8.1 Fitness for discharge

- Patient has to be hemodynamically stable.
- She has to have passed urine and stools after any procedure performed on her or after delivery
- In post delivered patients, baby discharge has to be done by the neonatologist.
- In high risk patients, fitness for discharge from the respective specialties has to be taken.

8.2 Discharge process

- Name of the patient, Address of the patient, OPD and IPD numbers has to be written correctly.
- Name of the respective unit, Date of admission and discharge & Provisional diagnosis has to be written correctly.
- Final diagnosis, investigations, condition on admission ,course in ward, treatment in ward,condition on discharge & treatment on discharge has to be written properly.
- Check that OT notes, discharge summary has been properly entered in discharge card.
- During discharge proper date and time of next follow up has to be advised.
- For antenatal patients, plan of action in case of high risk has to be written.
- For gynaecology patients, plan of action has to be written, especially patients who have undergone hystero-laparoscopy.
- For patients who have received blood transfusions,CPD bag no., date has to be written on discharge card.
- For the patients who have undergone the surgery histopathological report of removed
- specimen has to be given to patient or has to be adviced to collect it in her next follow up visit.
- Check whether TL money has been collected or not.
- Check RGJAY status, if applicable.
- Discharge cards have to be signed by JR &CR.In high risk cases and medicolegal cases, signature of Assistant professor has to be taken.

- All papers have to be numbered and arranged in serial order with the indoor paper, before being dispatched to the Medical Record Department. Discharge summary has to be given to the staff with signatures of the CR on the indoor paper with date.
- All relevant documents has to be handed over to the patient (OPD paper or the casualty paper,discharge card, all the investigation reports for which the patient has paid, original payment receipts), In case of discharge of a patient whose relatives are not available ,casualty officer has to be informed and permission has to be taken for the same.
- While giving early discharge to patients (Laparoscopic, Caesarean, Hysterectomy or other operative procedure), patient has to be advised to take antibiotics, analgesics and other necessary drugs as per prescription.
- Woman has to be advised to come for removal of stitches as per instruction given by seniors.

8.3 DAMA (Discharge against Medical Advise)

- DAMA (Discharge against Medical Advise)should be informed to CMO.
- Assistant professors have to be informed during emergency & working hours.
- DAMA stamp has to be taken on the front page of indoor paper and OPD paper and discharge card, along with date & signatures of the ward staff, unit registrar, patient and her relative. CMO call has to be documented on indoor paper in all DAMA cases.
- In case of DAMA of serious patient informed consent of the relative has to be taken and high risk of the patient and the consequences have to be explained.

8.4 Abscond Procedure

- Procedure has to be done by Staff Nurse if a patient is not found in or around the respective ward or in the hospital premises for a minimum time period of 3 hours.
- Written call to CMO and MS has to be sent.
- Entry has to be made by staff in the ward register– as patient absconded on date, time, with or without hospital clothes and with or without indoor papers.
- New admission has to be taken, if the patient comes back.

9. Medical Termination Of Pregnancy

1. Our institute is a recognized MTP center and follows all regulations laid by health ministry of family welfare.
2. All patients are offered safe abortion services under MTP ACT 1973
3. These services are offered on all OPD days. Number of visits to OPD are minimized before offering safe abortion services
4. For patients willing for termination of pregnancy, reason for termination of pregnancy is confirmed to be within the criteria of MTP ACT.
5. Ultrasonography (obstetrics) is done in all patients willing for termination of pregnancy to confirm site of pregnancy and gestational age.
6. Pelvic examination is done in all cases to confirm uterine size, any mullerian abnormality unless patient denies.

FIRST TRIMESTER ABORTION

- For first trimester abortion only basic investigations like haemoglobin, blood group and Rh type, urine routine and microscopy is done.
- If these investigations are within normal limits then patient is given option of medical termination or MVA.
- Patient is allowed to make informed consent.
- If patient opt for medical termination then MTP KIT (tab. Mifepristone 200 mg+ Tab. Misoprostol 800mcg) is prescribed as per the FOGSI protocol.
- Patient is asked to followup after 14 days for repeat USG to confirm completion of procedure.
- Patient is ask to come at any emergency hour if untoward complications arise eg. Hypersensitivity to drugs, excessive PV bleeding.
- Patients opting MVA (Suction & Evacuation) are admitted and posted for next OT.
- All admitted patients undergo Pre anaesthetic checkup and if needed additional investigations are done depending on associated medical disorders.(Hypertension, Diabetes mellitus, heart disease)
- Patients undergo pre op preparation with vaginal misoprostol 400 mcg 4 hours before procedures.

- MVA is performed under TIVA , under supervision of senior consultant.
- In case of suspected complication or difficulty case is taken over by senior consultant. Need of additional help from surgery consultant may be seeked.
- Patients willing for CuT insertion or tubal ligation, procedure is completed in same setting.
- All events of procedure are noted in OT notes on same day and countersigned by operating surgeon and Consultant.
- Patient is monitored closely and discharged on same day (MTP or MTP + CuT) OR next day (MTP + TL)
- On discharge patient is given discharge card.
- At no time patients name is mentioned on indoor file, consent form or discharge card.
- MTP no. is assigned for each case.

SECOND TRIMESTER ABORTION

- For second trimester abortion opinion of two assistant professors is taken.
- After admission patients are induced with tab. Misoprostol (dose is decided on basis of gestation age , cervical score and previous uterine surgery)
- After abortion abortus is weighed. Abortus is handed over to relatives with consent.
- All events of procedure are noted in IPD paper on same day and countersigned by Consultant.
- On discharge patient is given discharge card.
- At no time patients name is mentioned on indoor file, consent form or discharge card.
- MTP no. is assigned for each case.

FOR ALL CASES

1. In all admitted cases prophylactic antibiotic are given.
2. All Rh negative patients are given Anti D injection within 72 hours of abortion.
3. On discharge patients are advised contraception if not already chosen.
4. Every patient’s FORM I, FORM II, AND FORM C are completed.
5. All cases are entered in MTP register (Maintained in accordance of government law).

6. FORM II , Regulation 4(5) Reporting format for MTP is filled at the end of every month and data is sent to civil surgeon before 5TH of every month , along with online submission.
7. All consent forms (FORM I, FORM C) are kept in separate confidential file. All the data is reproduced whenever inspector come from Civil hospital. At no time during inspection of MTP center data involving name of patients is revealed.

10. MEDICOLEGAL CASE (MLC)

10.1 Delivery in case of MLC patient

- Call has to be sent to Casualty officer along with file.
- MLC stamp has to be put on the Casualty paper and Indoor paper.
- Social worker call has to be done.
- Forensic Medicine reference has to be done if required.
- Routine antenatal investigations have to be done. Investigations should be done to rule out STDs.
- After delivery, Cord blood and mother's blood samples have to be sent for DNA analysis if required.
- Mother has to be shifted to respective ward, File has to kept with staff.
- Suppression of lactation has to be done (if indicated).
- Baby kept as extra baby in postnatal ward has to be looked after by staff nurse.
- Community Development Officer (MSW) reference has to be sent.
- At discharge check.
    - Baby's adoption work has to be complete.
    - Mother's fitness for discharge.

10.2 Medicolegal care for survivor / victims of sexual violence :

Guidelines & Protocols

- Health professionals play a dual role in responding to the survivors of sexual assault. The first is to provide the required medical treatment and psychological support. The second is to assist survivors in their medico-legal proceedings by collecting evidence and ensuring a good quality documentation.
- After making an assessment regarding the severity of sexual violence, the first responsibility of the doctor is to provide medical treatment and attend to the survivor's needs.

- While doing so it is pertinent to remember that the sites of treatment would also be examined for evidence collection later. Section 164 (A) of the Criminal Procedure Code lays out following legal obligations of the health worker in cases of sexual violence:

- Examination in a case of rape shall be conducted by a Registered Medical Practitioner (RMP) employed in a hospital run by the government or a local authority and in the absence of such practitioner, by any other RMP.
- Examination to be conducted without delay and a reasoned report to be prepared by the RMP.
- Record consent obtained specifically for this examination.
- Exact time of start and end of examination to be recorded.
- RMP to forward report without delay to Investigating Officer (IO), and in turn IO to Magistrate.
- The Criminal Law Amendment Act 2013, in Section 357C Cr.PC says that both private and public health professionals are obligated to provide treatment.
- Denial of treatment of rape survivors is punishable under Section 166 B IPC with
- imprisonment for a term which may extend to one year or with fine or with both. Health
- professionals need to respond comprehensively to the needs of survivors.

One Page Instructions For Doctors :

The examining doctor should carefully read the Guidelines for responding to survivors of sexual violence issued by the MOHFW, and should he well aware of the comprehensive care to be provided.

1. Informed consent : Doctors shall inform the person being examined about the nature and purpose of examination and in case of child to the child's parent/guardian/person in whom the child reposes trust. This information should include:

a. The medico-legal examination is to assist the investigation, arrest and prosecution of those who committed the sexual offence. This may involve an examination of the mouth, breasts, vagina, anus and rectum.

b. To assist investigation, forensic evidence may be collected with the consent of the survivor. This may include removing and isolating clothing, scalp hair, foreign substances from the body, saliva, pubic hair, samples taken from the vagina, anus, rectum, mouth and collecting a blood sample.
c. The survivor or in case of child, the parent/guardian/person in whom the child reposes trust,has the right to refuse either a medico-legal examination or collection of evidence or both, but that refusal will not be used to deny treatment to survivor after sexual violence.
d. As per the law, the hospital examining doctor is required to inform the police about the sexual offence. However, if the survivor does not wish to participate in the police investigation, it will not result in denial of treatment for sexual violence. Informed refusal will be documented in such cases.

2. Per vaginum examination : commonly referred to by lay persons as two-finger test', must not be conducted for establishing an incident of sexual violence and no comment on the size of vaginal introitus, elasticity of the vagina or hymen or about past sexual experience or habituation to sexual intercourse should be made as it has no bearing on a case of sexual violence. No comment on shape, size, and / or elasticity of the anal opening or about previous sexual experience or habituation to anal intercourse should be made.

3. Injury documentation : Examine the body parts for sexual violence related findings (such as injuries, bleeding, swelling, tenderness, discharge). This includes both micro mucosal injuries which may heal within short period to that of severe injuries which would take longer to heal.
Please refer to section VI Point 17 of the Guidelines.
Injuries must be recorded with details -size, site, shape, colour.
If a past history of sexual violence is reported, then record relevant findings. Sexual violence largely perpetrated against females. but it can also be perpetrated against males, transgender and intersex persons.

4. The nature of forensic evidence collected will be determined by three main factors - nature of sexual violence, time lapsed between incident of sexual violence and examination and whether survivor has bathed or washed herself. Please refer to Section VI Point 21 of Guidelines.

5.Opinion : The issue of whether an incident of rape/sexual assault occurred is a legal issue and not a medical diagnosis. Consequently, doctors should not, on the basis of the medical examination conclude whether rape/sexual assault had occurred or not.

Facilitating procedures :

- The health worker should explain to the survivor in simple and understandable language the rationale for various procedures and details of how they will be performed.
- Specific steps when dealing with a survivor from marginalized groups such as children, persons with disability, LGBTI persons, sex workers or persons from minority 9 community, may be required as recommended .
- Ensure confidentiality and explain to the survivor that she/he must reveal the entire history to health professional without fear. The survivor may be persuaded not to hide anything.
- The fact that genital examination may be uncomfortable but is necessary for legal purposes should be explained to the survivor. The survivor should be informed about the need to carry out additional procedures such as x-rays, etc which may require him/her to visit to others departments.

While performing the examination, the purpose of forensic medical examination is to form an opinion on the following :

- Whether a sexual act has been attempted or completed. Sexual acts include genital, anal or oral penetration by the penis, fingers or other objects as well as any form of non consensual sexual touching. A sexual act may not only be penetration by the penis but also slightest penetration of the vulva by the penis, such as minimal passage of the glans between the labia with or without emission of semen or rupture of the hymen.
- Whether such a sexual act is recent, and whether any harm has been caused to the survivor's body. This could include injuries inflicted on the survivor by the accused and by the survivor on the accused. However, the absence of signs of struggle does not imply consent.
- The age of the survivor needs to be verified in the case of adolescent girls/boys.

- Whether alcohol or drugs have been administered to the survivor needs to be ascertained.

10.3GUIDELINES FOR RESPONDING TO CHILDREN :

- The prevalence of child sexual abuse in India is known to be high. A National Study on Child Abuse conducted by the Ministry of Women and Child Development showed that more than 53 per cent children across 13 states reported facing some form of sexual abuse while 22 percent faced severe sexual abuse. Both boys and girls reported facing sexual abuse. Most commonly,abusers are persons who are well known to the child and may even be living in the household.
- Children are considered soft targets for sexual abuse because they may not realize that they are being abused. Abusers are also known to use chocolates and toys to lure children.
- Further,children are more easily threatened and less likely to speak out about the abuse. While the principles of medical examination and treatment for children remains the same as that for adults, it is important to keep some specific guidelines in mind.
- In case the child is under 12 years of age, consent for examination needs to be sought from the parent or guardian.
- Children may be accompanied by the abuser when they come for medical treatment, so be aware and screen when you suspect abuse. In such situations, a female person appointed by the head of the hospital/institution may be called in to be present during the examination.
- Do not assume that because the child is young he/she will not be able to provide a history.
- History seeking can be facilitated by use of dolls and body charts.
- Believe what is being reported by the child. There are misconceptions that children lie or that they are tutored by parents to make false complaints against others. Do not let such myths affect the manner in which you respond to cases of child sexual abuse.
- Specific needs of children must be kept in mind while providing care to child survivors. Doses of treatment will have to be adjusted as required in terms of medical treatment.

- For psychological support, it is imperative to speak with the carer/s of the survivor in addition the survivor themselves.
- Health professionals must make a note of the following aspects while screening for sexual abuse. Assurance of confidentiality and provision of privacy are keys to enabling children to speak about the abuse. However genital and anal examination should not be 18 conducted mechanically or routinely.
- A few indicators for routine enquiry are – - Pain on urination and /ordefecation - Abdominal pain/ generalized body ache - Inability to sleep - Sudden withdrawal from peers/ adults - Feelings of anxiety, nervousness, helplessness - Inability to sleep – Weight loss - Feelings of ending one's life

11. MATERNAL DEATH SURVEILLANCE RESPONSE MEETING

Checklist for every case :

- ✓ Submission of maternal death report to the quality assurance committee within 24 hours.
- ✓ Submission of maternal death form, duly filled, with summary and photocopy of the indoor case paper to the quality assurance committee within 72 hours.
- ✓ Submission of maternal autopsy report to quality assurance committee when it is received.

Checklist for conducting authority :

- ✓ Maintenance of a list of all maternal deaths occurring in the month reviewing the forms and listing the departments and units involved.
- ✓ Dispatch of letters to all Heads of Surgery, Medicine, Anaesthesiology, Transfusion Medicine, of Antenatal Ward and Labour Ward regarding the time and date of meeting, to ensure their attendance.
- ✓ Dispatch of letters to all the respective departments regarding time and date of meeting, to ensure their attendance.
- ✓ Carry attendance sheets to the meeting: committee members, general. Submission of recommendations decided in the meeting and the autopsy reports to the quality assurance committee.
- ✓ Utmost efforts shall be taken to prevent maternal death. Treatment should be instituted to all critically ill patients for better outcome.

If unavoidable maternal death occurs then follow following checklist.

- ✓ Declare death in sensible manner, Preferably by Assistant Professor.
- ✓ Inform HOU & HOD.
- ✓ Inform nodal officer of OBGY within 24 hours.
- ✓ Get proper notes including resuscitation notes.
- ✓ Arrange pages as per chronology.
- ✓ Prepare death summary.
- ✓ Prepare death certificate with sign of Assistant
- ✓ Professor with cause of death & approval of Unit Incharge.
- ✓ Fill the MDR forms immediately.
- ✓ Get xerox of indoor case sheets.
- ✓ Mail MDR filled form to obgy@vims.edu.in
- ✓ Take signature of unit Incharge on case sheet.
- ✓ Be ready to face audit in first week of every month.