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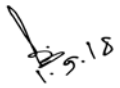
Approved by: Dr.R.Pohsnem Sr. M&HO I/C. Nartiang PHC  Signature & Date	**SOP NO. 10** **STANDARD OPERATING PROCEDURE FOR LABOR ROOM**	Page 1of 43

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Distribution list of the SOP

The Controlled Copy of the SOP bearing the red stamp 'CONTROLLED COPY' will be distributed to the following designated persons:

Sr.no.	**Designation**
1	MO
2	Staff Nurse Labor Room

SOP:10 Labour Room

1. **Purpose:**

   To develop systems for ensuring care of pregnant women from antenatal to postnatal period and also address the needs of the newborns. It includes a comprehensive approach to reduce maternal, neonatal, and infant mortality.

2. **Scope:**

It includes

- Antenatal care
- Intra-partum care
- Safe delivery
- Postnatal care
- Immunization
- Family planning

3. **Timings:**
   Delivery Services are available 24x7

4. **Responsible persons:**

- In charge of hospital – Medical Officer In charge
- MO on duty
- Staff nurse on duty
- ANM

5. **Quality policy**

Nartiang PHC is committed to provide high quality, affordable and accessible, preventive, curative, promotive health care services to the community and assure the best outcome through continual quality improvement

6. **Quality objectives:**

- To raise the Patient Satisfaction Score from current average score of 3 to 4.5 in 6 months time
- To ensure use of PPE by staffs during all procedures
- Ensure availability of all emergency drugs in the emergency tray
- To further improve hygiene and cleanliness in the Labor room as per the IP and BMW protocols

7. **Types of patients served:**

- Patients attending Outpatient services
- Patients attending emergency service
- Inpatients

8. Specific Procedure:

Sl no	Purpose	Responsibility	Reference document
1	**1.Service provision**		
	24x7 labour room service **RMNCH+A service** Management of Normal Deliveries, assisted vaginal deliveries(forcep/vaccum),Episiotomy & suturing of cervical & perineal tear, stabilization in obstetric emergencies before referral, management of pregnancy induced hypertension, prompt referral to nearest FRU	Medical Officer In charge Staff Nurse-Labour Room	**IPHS for PHC**
	Diagnostics service **Availability of rapid HIV & Blood sugar test**		
2	**Preparation of Labour room** ▪ The labour room is prepared & kept ready with all equipment required as per Labour room checklist ▪ Privacy is ensured to pregnant women with curtains & visual blocks	Staff nurse(Primary responsibility)	
3	**Patient Rights**		
	To greet respectfully the PW and the family members accompanying her ▪ To strictly avoid derogatory comments& to ensure respectful maternity care ▪ LR procedure is explained to the PW and the attendant ▪ Written Consent of the PW(for illiterate thumb impression) is to be taken before procedure including referral ▪ Female staff must be present while a male doctor is examining the pregnant women ▪ No overcrowding is allowed in the labour room		**Consent form**

4. Admission/shifting/referral Criteria in labour room

Sl.no	Activity	Responsibility	Reference document
	Procedure for Admission / Shifting / Referral: **Admission in Labour Room** ▪ The Pregnant women are admitted to the labour	**Medical officer** **Staff Nurse-Labour room**	**Bed head ticket** **Labor room**

	room when they arrive in Labour with cervical dilation =or>4cms ▪ Pregnant women directly reaching labour room to be received by Medical Officer / nursing staff on duty. ▪ Medical officer /Staff nurse to analyze the condition of the patient by taking history and reviewing past records including referral slip, if available, to assess any complications associated with pregnancy. **Shifting from & shifting to Labour room** ▪ If pregnant woman is in first stage of labour she is shifted to pre partum observation beds where vitals and dilation is monitored on periodic basis and partograph is established. ▪ If pregnant woman is in active first stage of Labour she is shifted to labour room. **Referral from Labour room** ▪ Pregnant woman requiring emergency C-Section to be immediately referred by ambulance to the nearest facility conducting C-Section delivery ▪ Timely referral to the appropriate facility by free referral transport is to be ensured **Others** ▪ Pregnant women in false labour / Observation are monitored and subsequently discharged.. ▪ **For every admitted pregnant woman bed head ticket is generated and entry is done in IPD register** ▪ Shifting of Patient to concerned Ward : Patient is shifted to the concerned in-patient facilities accompanied by the patient attendant ▪ Stretcher/wheel chair/Trolley are used for shifting of patient as required.		**register**

Activity	**Responsibility**	**Reference**
Rapid Initial Assessment **Rapid initial assessment must be conducted to identify if any of the following complications are present in the pregnant women to prioritize care & the conditions are following-** ✓ **Difficulty in breathing** ✓ **Fever** ✓ **Severe abdominal pain** ✓ **Convulsion or unconsciousness** ✓ **Severe headache or blurred vision**	**Staff Nurse(Primary)** **MO**	**Bed head ticket**

Recording & reporting of Clinical history ✓ **Recording of women obstetric history including LMP & EDD parity, gravid status, h/o C/S, live birth,stillbirth, medical history(TB,heart disease, STD,HIV status & surgical history** **Recording current labour details** ✓ time of onset of contraction ✓ Frequency of contraction ✓ Time of bag of water Leaking/bleeding PV ✓ Colour & smell of fluid & baby movement **Abdominal examination is done to check following parameters** ✓ Fundal height ✓ Fetal lie & presentation ✓ Fetal heart rate (FHR) ✓ Frequency, duration and intensity of contraction **Per vaginal examination is performed** ✓ Strict asepsis (hand hygiene, sterile gloves and cleaning of vulva using antiseptic) is followed ✓ Cervical dilatation and effacement are determined ✓ Status of presentation and membranes is seen ✓ Color of liquor is noted if membrane is already ruptured ✓ Station of the presenting part is checked Determine adequacy of pelvis for a normal labor. **Signs of true labor are looked for** ✓ Painful contractions ✓ Blood-stained mucus discharge from vagina (—show‖) ✓ Formation of bag of water.		
Reassessment ✓ Reassessment is to be done at fixed	Staff nurse(primary responsibility)	

schedule as per standard protocol		
Procedure for identification of patients, hand over & maintenance of nursing records ✓ Identification tags for mother & baby/foot prints for identification of newborns ✓ Patient hand over to be given during the change of shift ✓ Patient vitals to be monitored & recorded periodically for BP, pulse, temp, respiratory rate, FHR, uterine contractions any other vital required is monitored	Staff nurse(primary responsibility)	**Bed head ticket**

5. Preparation for conducting delivery

Activity	**Responsibility**	
The labor Room is prepared and kept ready before hand with all necessary equipment as per the Labor Room checklist Equipments ready Trays ready Baby tag Adequate privacy for the mother with curtains and visual blocks is ensured	**Staff nurse(primary**	**M&H tool kit**
Communication with pregnant woman and her family o Mother and accompanying family members are greeted respectfully o It is ensured that no derogatory comments are made o LR procedure is explained to the mother and the attendant o Consent of the mother is taken before starting any physical and vaginal examination	Staff Nurse(primary)	
Supportive care in Labour Room		
✓ Mother is encouraged to walk around and pass urine frequently ✓ A relative is allowed to stay with the women as birth companion	Staff Nurse(primary)	

✓ Mother is instructed to eat and drink frequently. She is advised to take light food like-tea, milk, biscuits etc. and avoid heavy meals. ✓ She is advised to adopt posture of her choice and do slow and deep breathing during contractions		

Activity	**Responsibility**	**Reference document/Record**
6.Intra Partum Care	Staff Nurse(Primary)	
Identification of stage of labor **1st stage (latent phase)** cervical dilatation: 0-3 cm; weak and infrequent contractions **1st stage (active phase):** cervical dilatation 4 cm or more, strong and frequent contractions **2nd stage:** cervix fully dilated till delivery of baby **3rd stage:** after delivery of baby until delivery of placenta		
1st stage **Monitoring is done every 1 hour** i)BP, temperature and pulse ii)Uterine contractions and fetal heart rate iii)**PV examination every 4 hours** iv)Cervical dilatation, effacement, status of membranes, station of head, color of liquid if membrane ruptured. v)Unless indicated vaginal examination is not performed more frequently than once every 4 hours vi)If any complication is seen the medical officer is called in for further management vii) **Refer to appropriate higher facility if no progress in cervical dilatation in 8 hours despite strong and frequent uterine contraction.** viii)If after 8 hours contraction subsides and there is no progress of cervical dilatation-it is probably false Labor and woman is discharged. She is advised to keep a fetal movement count (10 movements in 12 hours) and return if labor pains recur or there is bleeding or leaking per vaginum		Partograph
1st stage Pregnant woman is not left alone The women is allowed to deliver at her preferred position **Following signs are monitored every 30 minutes:**	Medical officer/Staff Nurse (Primary	

- ✓ Frequency of contraction
- ✓ FHR (fetal heart rate)
- ✓ If membranes ruptured color of liquor is noted
- ✓ For any complication

Mother is monitored every 4 hours for:

- ✓ Pulse, BP
- ✓ PV examination is done and following observations are looked for: Cervical dilatation and effacement, status of membrane and color of liquor
- ✓ Descent of presenting part Partograph is plotted- when the woman reaches active labor.

The following points are noted:

Fetal condition

- ✓ Fetal heart rates are counted every half hour. Count the FHR for one full minute. The rate is counted immediately following a uterine contraction. If the FHR is >160/minute or <120/minute, it indicates fetal distress. It is managed as mentioned in
- ✓ Woman is observed every 30 minutes for any leaking PV. If present, the color of the amniotic fluid is noted as visible at the vulva, recorded as

i) Clear (mark .C.)
ii) Meconium stained (mark .M.)
iii) No liquor (mark .A.)
iv) Labor- Plotting is done on the partograph once the woman is inactive labor.

- ✓ Active labor is present if cervical dilatation is 4 cm or more with at least 3 good uterine contractions (i.e. each lasting for more than 30-40 seconds) per 10 minutes.

Cervical dilatation is recorded in cm in the beginning and every 4 hourly

- ✓ Every half hour the number of good contractions (lasting over30-40 seconds) in 10 minutes are recorded, and appropriate boxes are blackened
- ✓ Initial recordings are placed to the left of the Alert Line and normally the line should continue to remain to the left of the Alert Line). Write the time accordingly in the row for time.
- ✓ If the Alert Line is crossed (the graph moves to the right of the Alert Line) it

indicates a prolonged labor. The time is noted when the Alert Line is crossed. Medical officer is called to reassess/monitor: i) The woman is encouraged to empty the bladder. The woman is reassessed in 2 hours if no progress, the obstetrician is called in for further management. ii) Crossing of the Action line (the graph moves to the right of the action line) the obstetrician is called in for further management. iii) Intervention Any drug administered during labor, is mentioned in the record including the time dose and route of administration. **Maternal Condition** Maternal pulse and BP are recorded every half hour and plotted on the partograph. Both systolic and diastolic BP are recorded using a vertical arrow.		

2nd Stage of Labour

Activity	**Responsibility**	**Reference documents/Records**
2nd stage- delivery of the baby Findings are recorded regularly in labour record and partograph Following signs are monitored every 5 minutes: i) Frequency, duration and intensity of contraction ii) FHR iii) Perineal thinning and bulging iv) Visible descent of the fetal head during contraction v) Any complications as in Section **Delivering the baby** i) It is ensured that the newborn care corner is prepared and equipment for neonatal resuscitation are ready ii) It is ensured that the bladder is empty iii) The woman is encouraged to push if she has the urge to do so during contractions and relax in between. iv) Bearing down effort is not required until the head has descended into the perineum. Thus no active pushing is allowed v) Controlled delivery of head is ensured by taking the following precautions:	Medical officer/Staff Nurse (Primary)	**Partograph & bed head ticket**

i) The perineum is supported with the left hand during delivery and the anus is covered with a pad held in position by the side of the left hand and right hand is used to maintain the slight flexion of the head ii) Once head is delivered, assistance in delivery of the shoulders and the rest of the baby is provided iii) Spontaneous rotation and delivery of the shoulders is waited for iv) Gentle downward pressure is applied to deliver the top(anterior) shoulder v) The baby is lifted up towards mother's abdomen, to deliver lower (posterior) shoulder vi) The baby is placed on mother's abdomen in skin to skin contact (even before cutting the cord) vii) The time of birth is noted viii) The baby is dried immediately. The scrubbing of the vernix is avoided. ix) Baby's breathing is assessed while drying x) If baby is breathing well, no further action is taken. The clamping of the cord is delayed.(2-3 minutes) xi) If the baby is not breathing or he/she is gasping: Clamp and cut the cord and shift the baby to radiant warmer for resuscitation xii) 10 IU oxytocin is given IM to the mother within 1 min of the delivery of the baby xiii) If heavy bleeding 10 IU Oxytocin IM is repeated in 10minutes xiv) Baby is placed on the mother's abdomen for skin-skin contact xv) Clamping and cutting of the cord. If the baby is crying: the clamping of cord is delayed and the cord is tied and cut between 1-3 minutes Clamps are put on the cord at 2 cm and 5 cm from the baby's abdomen. Cord is cut between the ties with a sterile blade. Oozing of blood from the stump is looked for. If there is oozing, a second tie is placed between the baby's skin and the first tie. xvi) Initiation of breast feeding is encouraged and ensured Immediately after birth or within an hour Precautions/ Emergency signs: If the woman has tight perineum, which may interfere with delivery, episiotomy is given and the delivery of head is controlled carefully. **Routine episiotomy is not**		

performed without indication xvii) **Stuck shoulder (shoulder dystocia)** Medical officer (who is readily available)is called for the help. Liberal episiotomy is done. The assistant is asked to apply supra-pubic pressure and the person who is conducting delivery applies gentle downward traction on the fetal head. If unsuccessful, patient is referred urgently to higher facility.		

3rd stage- Delivery of the placenta **It must be ensured that palpation of mothers abdomen conducted to rule out presence of second baby** i.Signs of placental separation are looked for and placenta is delivered by controlled cord traction **Signs of placental separation:** Lengthening of the cord, fresh gush of blood, supra-pubic bulge, and placenta lying in the vagina ii.**Delivery of the placenta:** Left hand is placed over pubic symphysis and the fundus of uterus is pushed up. Right hand is used to apply controlled downward traction on the cord to pull the placenta out. If placenta does not descend, both cord traction and counter traction are released on the abdomen until uterus contracts again and then the above step is repeated iii. **After delivery of the placenta:** It is checked if the uterus is well contracted and there is no heavy bleeding. Examination is repeated every 15 minutes for first hour of delivery. Inj 10 IU oxytocin is injected within 1minute of birth after ensuring that there is no second baby through palpation of mothers abdomen. Controlled cord traction is done during contraction. After expulsion of placenta check for placenta and membranes for completeness. If uterus is relaxed and there is heavy bleeding, the uterus is massaged and 10 IU oxytocin IM is given stat. 10 IU of oxytocin infusion (in 500 cc ringer lactate) is started at 60 drops per minute. Bladder is emptied. If bleeding persists and uterus is soft, continued massaging of uterus is done and bimanual compression is applied. IV fluids with 10 IU oxytocin are continued at 30 drops per minute, if bleeding gets controlled. iv. **Check the perineum, cervix and vagina** for tears. Repair if needed. v.Blood loss is estimated and recorded throughout third stage and immediately afterwards.		

vi.If blood loss equals to or more than 500 ml management of PPH is to be done as per standard guidelines. Intensive monitoring is done (every 30 minutes) for 4 hours for i.BP, Pulse ii.Respiratory rate iii.Uterine contraction to make sure it is well contracted iv.Vaginal bleeding v.The woman is assisted when she first walks after recovering vi.Mother and baby are kept in delivery room for a minimum of one hour after delivery of placenta vii.The placenta is disposed as per biomedical waste management rules, 2016The obstetrician is called in for further management if i.Unable to remove placenta by 1 hour after delivery or if blood loss is more than 350 ml and bleeding still continues (more than 3 pads soaked in 5 minutes): the uterus is massaged until hard, oxytocin infusion @ 40- 60 drops /min is continued and pulse and BP are checked every 15 minutes. **If baby is still born** Supportive care is given o The parents are informed as soon as possible o The possible causes of death are discussed with mother and her family o Body is handed over to relatives o The record is maintained in death register		

7.Care of the mother & newborn after delivery

Activity	**Responsibility**	**Reference documents/Records**
Findings, treatment and procedures are recorded in the patient's labor record i. Mother and baby are kept under observation in delivery room. They are not separated. ii. The mother and the newborn are not left alone **ii.** Breast	Staff Nurse(Primary	Bed head ticket

feeding is ensured **within first hour& recorded**		

Care of the mother

Activity	**Responsibility**	**Reference documents/Records**
Watch for vitals, urine output, bleeding per vaginum and uterine tone i. Assessment is done every 30 minutes for next 2 hours, then every 6 hours up to 48 hours. ii.The woman is encouraged to pass urine iii.In case of excessive bleeding, the management of PPH is done as per standard guidelines iv.Mother is encouraged to eat and drink, and rest. v.Birth companion is asked to stay with the mother and newborn. Mother and newborn are not to be left alone. The companion is instructed to call for staff nurse in case the mother has the following danger sign like: o Feels dizzy o Severe headache, visual disturbance o Pain in the abdomen o Increased pain in the perineum o Excessive bleeding If unable to manage, MO is called for further Management	Medical officer/Staff Nurse (Primary	Bed head ticket

Care of the Newborn

Activity	**Responsibility**	**Reference documents/Records**
Care of the newborn: i. The baby is dried. Vernix is not removed and the baby is not given a bath. ii. The mother and baby are allowed to remain together for skin-to -skin contact. Both of them are covered with a blanket. iii.The mother is encouraged and supported to continue breastfeeding. The newborn is not given anything other than own mother's milk. iv) The weight of newborn is measured o If birth weight<1800g then the baby is immediately referred to SNCU / higher facility. v.The baby is assessed every 30 minutes till 2 hours for: o **Any emergency signs**(mother and / or companion also to be explained) like: i)Lethargy or cyanosis ii)Pallor iii)Difficulty in breathing iv)Grunting v)Fast breathing (>60/min) vi)Chest in-drawing vii)Convulsions o Body temperature o Bleeding from the umbilical cord. Breast-feeding is assessed o To see if the baby is able to attach correctly and is positioned well o To check if the baby is sucking effectively . If treatment is not possible at the facility, then the baby is referred to the higher facility immediately& referral slip is issued with a copy of the same retained at the facility & also recorded in referral out register		**Bed head tcket**

8.Neonatal Resucitation

Activity	Responsibility	Records/
Resuscitation is started immediately if the baby is not breathing or gasping Neonatal resuscitation is discontinued if there is no sign of life after 10 minutes of resuscitation. Prognosis of newborn is discussed with parents before discontinuing resuscitation. o The baby is kept warm o The cord is clamped and cut o The baby is transferred to a dry, clean and warm surface like under a radiant heater o The head is positioned in slight extension and turn the head to over side o The airway is opened o First the suction of mouth is done and then the nose if required **Newborn resuscitation procedure** The suction tube is introduced into the newborn's mouth5-cm from lips and suck while withdrawing, The suction tube is introduced 3-cm into each nostril and suck while withdrawing until no mucus. Each suction is repeated if necessary o Tactile stimulation is given o Reposition o If still no / irregular breathing and HR > 100/ minute then refer Mask is placed to cover the chin, mouth and nose and form a seal, Ambu bag is squeezed and rising of chest is observed, If breathing or crying with more than 30 breaths per minute and no severe chest in-drawing, ventilation is stopped. Evaluate after 30 sec, if HR increasing continue PPV. If HR <60 per minute, start chest compressions in ratio of 3 chest compressions to one breath per minute Discontinue when HR increases to more than 60 per minute and breathing stabilizes.	MO/ Staff Nurse	

In case of deterioration inspite of PPV, call for additional help from medical expert for further resuscitation.(Ref to Annexure on NNR) Baby is kept under observation in Radiant Warmer when baby is stabilized (HR > 100 bpm & breathing well) then kept in skin-skin contact with mother's chest Baby is monitored every 15 minutes for breathing and warmth If breathing is less than 30 breaths per minute or severe chest in drawing, ventilation is continued Immediate referral to District Hospital is arranged. o If no breathing at all after 20 minutes of ventilation Ventilation is stopped. The baby is declared dead Mother is explained and supportive care is given to her. The event is recorded.		

9. Management of high risk pregnancy

Activity	**Responsibility**	**Reference document/records**
High Risk Pregnancy cases are patients who have associated problems with Pregnancy such as: 1. Grand multipara 2. Previous 3rd stage abnormalities / problems 3. All major Medical Disorders 4. Multiple Pregnancy 5. All mal-presentations 6. BOH 7. CPD 8. APH 9. Previous LSCS 10. PIH/ Eclampsia, Gestational Diabetes 11. Recurrent premature labour 12. Rh negative women with Rh positive husband 13. Gynaecological abnormality 14. Elderly primi 15 History of Infertility 16. Gross obesity		High risk case register, Labor room register

17. Oligo/Polyhydramnios 18. Extremes of age regardless of parity, < 18 yrs / > 35 yrs. Both are in need of attention, medical or social, due to various problems.		

Activity	**Responsibility**	**Reference document/records**
Management of 1st stage of labour in High Risk Pregnancy: The patient is informed about the condition, counselling is done and consent is taken by the nurse in-charge and medical officer. A partograph is established by staff nurse. Monitoring & charting of uterine contraction, Foetal heart rate, emergency signs, cervical dilation, BP, temperature and Pulse is done on periodic basis depending upon low/ high risk pregnancy and progress is updated in partograph. In any condition of unsatisfactory progress of labour due to prolonged latent phase, non progress of labour, prolonged active phase, foetal distress, cephalopelvic disproportion, obstruction, mal-presentation, mal-position, prolonged expulsive phase, the patient should be referred Decision about induction or augmentation of labour, vacuum extraction, forceps delivery, .	Medical Officer/ Nurse in-charge	Bed head ticket, partograph

Activity	**Responsibility**	**Reference document/records**
Management of 2nd stage of labour in High Risk Pregnancy: Uterine contraction, FHR, Perineal thinning & Bulging, visible descent of foetal head during contraction and presence of any sign of emergency is monitored periodic basis depending upon the low or high pregnancy.	Nurse in charge	

Delivery of baby and time of delivery is noted. Cord is tied and cut with a sterile blade after 2-3 minutes of delivery. Immediate newborn care is given. If newborn cries in 30 seconds newborn resuscitation is started		

Activity	**Responsibility**	
Management of obstretic emergency **i)**Initial Management of eclampsia/pre eclampsia ✓ Monitor BP ✓ Testing of protein urea if BP is >140/90mmHg with convulsion and protein urea following management is done by positioning women on her left side. use padded mouth gag after convulsion is over to ensure clear airway. ✓ Perform gentle air suction ✓ Provide inj magnesium sulfate5g(10ml.50%)in each buttock deep intra muscular ✓ If delivery is not eminent refer to FRU Post Partum Haemorrhage ✓ PPH if >500ml or>1pad soaked in 5minutes following measures undertaken for IV fluid, bladder catheterization, measurement of urine output (i) Administration of 20IU of oxytocin in 500ml normal saline or RL at 40-60drops per minute (ii) Performing bimanual compression of uterus if placenta is not delivered continuing inj.oxytocin 20IU in 500ml RL@40-60 drops per minutes & patient referred to FRU Management of retained placenta (i) Administer another dose of oxytocin 20 IU in 500 ml of RL at 40-60 drops/min and patient is referred to FRU		**Partograph**

Activity	Responsibility	
Management of Atonic PPH ✓ Bimanual compression of uterus ✓ Continue inj oxytocin 20IU in 500 ml RL/DNS ✓ Administer Inj. methargine/tab misoprostol ✓ If bleeding not stopped patient is referred to FRU Management of obstructed labour ✓ Diagnoses obstructed labour based on data registered from the partograph. Re hydrate the patient to maintain normal plasma volume, checking of vitals, providing broad spectrum of antibiotics, performing bladder catheterization, taking blood for HB & grouping ✓ Delivery mode is decided as per the condition of mother & baby		

Management of 3rd stage of labour-High risk pregnancies

Activity	Responsibility	
Management of 3rd stage of labour in High Risk Pregnancy: Inj. Oxytocin or Misoprostol is administered. Controlled cord traction is done for assist expulsion of placenta. Uterine massage is given to prevent PPH If there is retained placenta or PPH it is managed as per standard protocol. BP, Pulse, Temperature, vaginal bleeding is monitored periodically for three hours. In case the child delivered is dead, then the body is handed over to relatives and record is maintained in death register as still birth.	Medical Officer/ Nurse in charge	Bed head ticket

10. Delivery and baby note

Activity	**Responsibility**	
Procedures in written patient records **i) Delivery note** Are adequately recorded with following informations- i) Outcome of delivery, date & time, gestation age, delivery conducted by, type of delivery ,any complications, indication of intervention, date & time of transfer, cause of death ii) Baby note are adequately recorded with information on crying of baby, essential newborn care, resuscitation if any , sex, weight, time of initiation of breastfeeding, birth doses, congenital deformity if any		**Bed head ticket/ Labor room register**
Drug administration & standard treatment guideline		
i) Every medical advice is accompanied with date, time& signature ii) Inj. oxytocin to be given within one minute of birth iii) Any adverse drug reaction is recorded& reported		

11. Immediate Post partum care

Activity	**Responsibility**	
Assessment is done for contraction of uterus, bleeding and for vaginal/ perineal tear. i. Sanitary Pad is placed under the buttock to collect the blood. Assessment of blood loss is done by counting the blood soak pads. ii.Vitals are monitored at periodic intervals. iii.Mother and newborn are kept together. Breast-feeding is encouraged**.** iv.Birth Companion is asked to stay with the mother. She was instructed to call for help in case of any danger	MO/Nurse	Guideline for Pregnancy care and management of obstetrics complication s for MO. Labor Room Register

sign. v.Weight of newborn is measured. vi.Information of mother and newborn is recorded in labour register. Newborn and Mother is given identification tags.		

12. Essential Care of New Born

Activity	**Responsibility**	
Essential new born care is given including maintain body temperature, maintaining airway & breathing, breast feeding of new born, care of cord and eyes	Staff Nurse	WI for Immediate Newborn Care WI for Preventing Hypothermia

13. Routine care of Newborn

Activity	**Responsibility**	
Wipe the baby with a clean pre warmed towel & wrap in Second pre warmed towel Delay in cord clamping & cutting(1-3 minutes)	**Staff Nurse**	
Record weight at birth		
Administration of inj Vit-K		

14. Neonatal Resuscitation

Activity	**Responsibility**	
The APGAR Score is calculated at 1st and 5th minute after birth. Resuscitation may be required in following condition If APGAR score is < 7 then immediate resuscitation is started. Neonatal resuscitation is discontinued only after 10 mins of resuscitation if there is no sign of life. Prognosis of newborn is discussed with parents before discontinuing resuscitation. All cases of still birth are also given resuscitation for at least for 10 mins.	MO/ Staff Nurse	APGAR Score Criteria WI for Neonatal Resuscitation

15. Referral of Newborn to SNCU

Activity	**Responsibility**	**Reference**
Referral of Newborn to SNCU If the new born is has any of any of following conditions- 1 birth weight < 1500 gms, Major congenital malformation Severe Birth Injury Severe Respiratory Distress PPV≥ 5 Minutes Needing Chest Compression or drugs Any other	MO/ Staff Nurse	FIMNCI Manual

indication decided by pediatrician. New born is kept under closed observation Birth Weight 1500-1800 New Born needing IPPV < 5 Vigorous babies with fast breathing		

16. Post natal inpatient care of newborn

Activity	Person responsible	
Post Natal Inpatient care of New Born After delivery; all new born not needing special care shifted to the Labour ward with mother for postnatal care and Postnatal ward is kept warm (25°C). New Born is kept with mother on the same bed right from the birth. Mother is encouraged to breast fed baby within 1 hr of delivery. Postnatal new born care includes review of labour and birth record, communication with mother, examination of baby, assessment of breastfeeding, cord care, skin & eye care, administration of Vit K, counselling of mother, immunization BCG, OPV-0, HepatitisB0dose (HB-1) and follow-up.		F. IMNCI Manual Guidelines for antenatal care and skilled birth attendance at Birth

17. Discharge of patients

Activity	Responsibility	
Discharge of Patient Discharge is done after delivery, depending upon the mother's condition but not less than 48 hours for normal delivery. Discharge slip is prepared by	Medical officer/ nurse in-charge	Discharge Slip Antenatal Care and Skilled Birth Attendance

the M.O. and entry is made in the discharge register by ward in-charge. Mother is briefed about postpartum care and hygiene, nutrition for self &Newborn, Exclusive breastfeeding follow-up advice, keeping baby warm, complete immunization of newborn post partum visits, family planning. She is also counselled about the danger signs that should immediately reported to the hospital relating her and new born.		at Birth

18. Post natal care after discharge

Activity	**Responsibility**	
Postnatal Care is provided through MCH clinic. Mothers referred to hospital form postnatal visits by ASHA/ANM for postpartum complication like PPH and puerperal sepsis, severe anaemia are assessed in OPD Clinic/ Emergency and admitted in the hospital if required**.**	MO	

19. Immunization

Activity	**Responsibility**	
The hospital immunization facility under universal immunization programme for children/new born/neonates which includes all vaccines e.g. OPV, PENTA, TT, BCG, Measles, fIPV etc. and register is maintained in the department by Sister In-Charge. Details of immunization	Immunization Nurse/ ANM	Universal Immunization programme Mother and Child Protection Card

given are entered on Mother and child protection card. Auto disable syringes are used for immunization. Any serious adverse event following immunization such as death, Hospitalization, disability and other serious events that are thought to be related with immunization are immediately reported to MS by Phone. Other Serious AEFIs such as anaphylaxis, TSS, AFP, encephalopathy, sepsis, event occurring in cluster are reported to district immunization officer within the prescribed time in prescribed format. All the serious AEFI are investigated by appropriate authorities and corrective action is taken. After each immunization parents are informed about- What vaccine is given and it prevents what. What are minor side effects and how to deal with them? When to come for next visit To keep mother and child protection card safe and bring it on next visit		

20. Counselling for the family planning

Activity	**Responsibility**	
The patient attending the ANC clinic / The clerk enters patient's details in the register and asks the patient to fill consent form The MO explains the couple on importance of family	MO/ PP Centre In charge	**Family planning register**

planning and the various permanent (NSV, Vasectomy, Female sterilization, Tubectomy) and temporary methods of family planning (PPIUCD) Condoms)		

21. Integrated Management of Neonatal Sickness

Activity	**Responsibility**	
Patients under age of 2 months are classified as sick young infants and patients under 5 year of age are classified as sick child. Their management is done as per Integrated Management Neonatal and Childhood Illness approach. This Includes: Urgent Referral Services at facility (Red) Urgent Referral Facility at Out Patient Department (Red) Treatment Facility at OPD (yellow) Home Management (green)	MO	IMNCI Guidelines & Guidelines for management of Sepsis in young infants.

22. Emergency Triage Assessment & Treatment

Activity	**Responsibility**	
Any sick young infant or child received in hospital is promptly attended and standard ETAT procedure followed for management.	MO/ Nursing Staff	WI- Steps in Management of Sick young Infants and Children.

Triage

Triage of all young infants and children is done in following categories as soon they arrive the hospital. -those Emergency signs (E)	MO/ Nursing Staff	WI- Triage

requiring Emergency Treatment - those Priority Signs (P) requiring rapid assessment and action - Non urgent (N) cases those can wait Triage is done by assessing Airway, Breathing, Circulation, Coma, Convulsion and Dehydration (ABCD). If no emergency sign is seen than priority signs are looked for.		

23. Assessment & Management of Emergency Signs in Newborns-

Activity	**Responsibility**	
Assessment and management of Emergency signs done as per standard F IMNCI Protocols. If any signs of hypothermia or hypoglycaemia are present their management is done simultaneously. **This includes -** Assessment for breathing, central cyanosis and severe respiratory distress Is done and Basic Life Support is given if required. Assessment & treatment of shock in young infant & children with or without severe acute malnutrition**.** Assessment and treatment of coma and convulsions. Assessment and treatment of severe dehydration Assessment and treatment of Hypoglycaemia and Hypothermia	MO/ Nursing Staff	

24. Facility based care Sick Young Infant

This includes fluid management, Management of Hypoglycaemia, Post resuscitation care of Asphyxiated newborn, management of septicaemia, meningitis, diarrhoea, tetanus neonatorum, Jaundice and monitoring of sick young infant	MO/ Nursing Staff	Checklist for Monitoring of Young Infants Guidelines for facility based new born care (FBNC)

25. Management of Low birth Weight Neonates

All low birth weight(below 1500 gm)Vit. K (0.5mg)intramuscular at birth. Neonates with birth weight less than 1800 gms are admitted in the hospital Normal body temperature of neonate is maintained through Kangaroo Mother care or through radiant warmer/ incubator as advised by the Doctor on duty. Fluids and nutrition is provided as per birth weight or gestation of the neonate	MO/ Nursing Staff	WI for modes of providing fluid and feeding. Indication of Discharge of LBW neonates.

26. Referral and Transport of Neonates-

Activity	**Responsibility**	
If management of newborn cannot be done at the hospital either due to lack of facilities neonate is referred to higher centre or other hospital. Receiving facility is communicated about the patient. Neonate is stabilized with	MO/ Nursing Staff	

respect to temperature, airway, breathing, circulation and blood sugar. A doctor/nurse/health worker is arranged for accompanying the neonate to receiving hospital if possible. Parents/attendants of newborn are communicated about the conditionof new born and instructions are given for care of newborn during transport. A referral note is prepared and given to patient's attendants describing condition of new born, reason for referral and treatment given.		

Activity	**Responsibility**	
Standard Infection Control Measures are taken to ensure prevent hospital acquired infections and safe work environment to service providers. These measures broadly includes – ✓ Strict adherence to standard hand washing Practices with 6steps ✓ use of personal protective equipment when handling blood, body substances, excretions and secretions ✓ no reuse of disposable mask, gloves,cap & apron ✓ decontamination of delivery table ,stretcher, trolley with wiping with 0.5% chlorine solution ✓ no sorting, rinsing, sluicing at point of use/patient care area ✓ cleaning of instruments is done with detergent after decontamination ✓ proper decontamination of instruments after use ✓ disinfection & sterilization of instruments & equipments	Staff Nurse on duty/MO	Infection Control Manual SOP for Hospital Waste Management SOP for Housekeeping Management National Infection Control Guidelines

prevention of needle stick /sharp injuries environmental cleaning and spills-management appropriate handling of Biomedical Waste Regular culture surveillance of labour room is done to ensure safe patient care environment. Regular monitoring of Episiotomy site infection rate		

27. Environmental Cleaning and Processing of equipment in LabourRoom-

Activity	**responsibility**	
External foot wears are not allowed in the labour room. It mandatory to wear dedicated labour room sleepers before entering the labour room. After every procedure all working surfaces are disinfected. Only staff that is required for procedures is allowed in labour room. Traffic in labour room is kept minimal.	Gr-iv staff	Infection Control Manual SOP on Housekeeping

28. Rights & Dignity of pregnant women

Activity	**Responsibility**	
✓ Simple and clear language is used while communicating with pregnant women. ✓ Pregnant woman is informed about the status of her health and supported to understand options and make decisions. ✓ Woman is made to feel as comfortable as possible when receiving services. ✓ Before any examination permission is taken from pregnant women and procedure is explained to her. ✓ During the examination privacy of patient of pregnant women is maintained. Screens and curtains are provided in examination area and it is ensured that woman is protected from view of other people. ✓ Pregnant women consent is taken before discussing with her family	MO/ Staff Nurse/ Other service Providers	

Confidential information about pregnant women is never discussed with other staff members or outside the facility. ✓ Informed consent is taken before any invasive procedure. ✓ Any pregnant woman with HIV is not denied on basis of HIV status. Her HIV status is kept confidential except to people who are involved in care.		

29. Procedure for record maintenance including consent form ✓ All patients records including consent forms, store inventories, equipment, annual maintenance documents, complaints, staff records, waste disposal records are well documented and kept in relevant files by Nurse supervisor. ✓ **Written consent form must comply to the following requirements:** i.The name(s) of all the practitioner(s) immediately responsible for the patient is mentioned. ii. Diagnosis is mentioned. iii.A brief description of the recommended treatment or proposed procedure. iv.A statement that relevant aspects of the treatment, or procedure, including indications, benefits, risks, and alternatives including no treatment have been discussed with the patient in language that the patient could understand; and that the patient indicated comprehension of the discussion. v.A statement that the patient had an opportunity to ask questions. vi.The date and time the discussion took place and whether the patient consented to the treatment or procedure. vii.The written signature of the practitioner writing the note (includingthe Practitioner's legibly written name). viii.Signature/Thumb impression of Patient/Next of Kin/Guardian as applicable and legible written name & relationship with the patient. ✓ Date of Consent		

✓ Consent form is filled completely with no blank space/ box. ✓ General consent is obtained at the time of admission, explaining the scope of such consent ✓ All procedures performed on the patient have separate consent taken for each of the procedures. ✓ Consent is signed by all the patients in Labour room. In case patient/ Next to Kin is illiterate then the thumb impression of the patient is taken which is witnessed by a neutral person. ✓ All consent forms are maintained in the patient case file		

30. Monitoring & quality control

Activity	**Responsibility**	
Maternal Death Review All maternal deaths occurring in the hospital including abortion and ectopic gestation related deaths, in pregnant women and mothers after within 42 days of termination of pregnancy are informed immediately by treating doctor to facility nodal officer MDR at the time of occurrence. The facility nodal officer (FNO) of the hospital inform the district nodal officer (DNO) and subsequently to state nodal officer within 24 hours. Facility nodal officer fill the primary informant format and sent it to (DNO) Maternal death is immediately investigated by medical officer treating the mother using facility based maternal death review format and submit it in triplicate to FNO within 24 hours. A facility Maternal Death Review committee is constituted as per MDR guidelines which reviews all maternal deaths occurred in monthly review meeting and suggest corrective action to improve the quality of care. Minutes of meeting of review meeting along with case summary are sent to district nodal officer**.**	Treating MO, FNO, DNO	FMDR Format Maternal Death Review Guidebook

31. Quality Assurance of Referral Services-

Activity	Responsibility	
Each woman who is referred to the district hospital is given a standard referral slip. This referral slip is sent back to the referring facility with the woman or the person who brought her after writing outcome of referral on it. Both the district hospital and the referring facility keep a record of all referrals as a quality assurance mechanism	Medical Officer in charge	

32. Different Trays in Labour Room:

S.No	Activity/ Description	Responsibility	Ref. Doc. /Record
1	**Delivery tray:** Gloves, scissor, artery forceps, cord clamp, sponge holding forceps, urinary catheter, bowl for antiseptic lotion, gauze pieces and cotton swabs, speculum, sanitary pads, Kidney tray.	MO & Staff Nurse on duty	
2	**Episiotomy tray:** Inj. Xylocaine 2%, 10 ml disposable syringe with needle, episiotomy scissor, kidney tray, artery forceps, Allis forceps, sponge holding forceps, toothed forceps, needle holder, needle (round body and cutting), chromic catgut no. 0, gauze pieces, cotton swabs, antiseptic lotion, thumb forceps, gloves.		
3	**Baby tray:** Two pre-warmed towels/sheets for wrapping the baby, cotton swabs, mucus extractor, bag & mask, sterilized thread for cord/cord clamp, nasogastric		

	Tube and gloves Inj. Vitamin K, needle and syringe. (Baby should be received in a pre-warmed towel. Do not use metallic tray.)		
4	**Medicine tray:** Inj. Oxytocin (to be kept in fridge), Cap Ampicillin 500 mg, Tab Metronidazole 400 mg, Tab Paracetamol, Tab Ibuprofen, Tab B complex, IV fluids, Inj. Oxytocin 10 IU, Tab. Misoprostol 200 micrograms, Inj. Gentamycin, Vit K, Inj. Betamethason, Ringer lactate, Normal Saline, Inj. Hydrazaline, Nefidepin, Methyldopa, magnifying glass.		
5	**Emergency drug tray:** Inj. Oxytocin (to be kept in fridge), Inj. Magsulf 50%, Inj. Calcium gluconate-10%, Inj. Dexamethasone, Inj. Ampicillin, Inj.Gentamicin, Inj. Metronidazole, Inj. Lignocaine-2%, Inj. Adrenaline, Inj. Hydrocortisone Succinate, Inj. Diazepam, Inj. Pheneraminemaleate , Inj. Carboprost, Inj. Fortwin, Inj. Phenergan, Ringer lactate, normal saline, Betamexthazon Inj. Hydrazaline, Nefidepin, Methyldopa, IV sets with 16-gauge needle at least two, controlled suction catheter, mouth gag, IV Canula, vials for Drug collection Ceftriaxone (3rd generation cephalosporins).		
6	**MVA/ EVA tray:** Gloves, speculum, anterior vaginal wall retractor, posterior vaginal wall retractor, sponge holding forceps, MVA syringe and cannulas, MTP cannulas, small bowl of antiseptic lotion, sanitary pads, pads /cotton swabs,disposable syringe and needle, misoprostol tablet, sterilized gauze/pads, urinary Catheter.		
7	**PPIUCD tray:** PPIUCD Insertion Forceps, Cu IUCD 380A/ Cu		

	IUCD 375 in a Sterile package.		

33. Disposal of BMW:

S.No	Activity/ Description	Responsibility	Ref. Doc. / Record
1	**Disposal of BMW** The human tissues, blood soaked sponges, patient blooded clothes, linen, cotton pads and other fluids discharged during the delivery are disposed off in the identified bin. Similarly, needles, syringes etc are discarded by using needle destroyer in the separate bin as per identification.	Doctor and Staff Nurse on duty	BMW Management & Handling Rules

34. Equipment Maintenance:

S.No	Activity	Responsibility	Records
1	All the measuring equipments /instruments shall be calibrated	MO I/C	Nil
2	An ISO certified calibration agency shall be identified to calibrate the equipments/instruments , with due approval from the state health department	MO I/C	Nil
3	Calibration labels / stickers shall be placed on the equipment denoting the date of calibration and indicating the status of calibration /verification when recalibration is due	Calibration agency	Equipment register
4	All calibration certificates shall be maintained by the in charge or centrally stored by the store in charge of the hospital	MO I/C	Calibration certificate
5	The ward shall maintain an equipment register to document details of equipment and calibration status	MO I/C	Equipment register
6	It shall be the duty of the in charge to ensure up-dation of calibration for all equipments as per their schedule	MO I/C	Equipment register
General Maintenance			

7	Defective/out of order equipments shall be labeled and stored appropriately away from ward area , until it has been repaired	MO I/C	Nil
8	Daily dusting/ dry wiping of equipments shall be done by housekeeping staff. The Laboratory technician shall do a daily check on functioning of equipments on every morning before commencement of testing procedure	MO I/C	Nil
9	An equipment register shall be maintained to document details of equipment – name, hospital code , date of installation name of manufacturer maintained in-house / maintained by external agency or manufacturer , warranty period, under AMC/CMC	MO I/C	Equipment register
Preventive and break down maintenance			
Preventive maintenance			
10	All equipments shall be covered under AMC/CMC including preventive maintenance	MO I/C	Equipment register
11	The lab in-charge shall maintain an updated record on AMC and preventive maintenance in equipment register this should include details like • Frequency of preventive maintenance/ calibration ➢ As per the manufacturer guidelines ➢ Presently being followed • Preventive maintenance/ calibrations done on • Preventive maintenance/ calibrations due on • Expenditure with cost and details • Remarks with functional status	MO I/C	Equipment register
12	Preventive maintenance shall be carried out as	MO I/C	Equipment

	per maintenance schedule for each individual equipments based on manufacturer recommendations		register
13	The following shall be checked during the preventive maintenance • Physical condition of equipment / facility • Lubrication calibration cleaning or replacing parts that are expected to wear or which have a finite life • Maintenance report verification Maintenance / service report shall be obtained from service agency and after verification marked as OK/ not OK	MO I/C	Equipment service report
Break down maintenance			
14	Faulty or defective equipment shall not be used regardless of how minor is the problem and must be reported in the first instance to the in-house maintenance engineer / outside agency hired for maintenance as soon as possible and seen that the problem is attended to as soon as possible	MO I/C	Equipment register
15	A Red tagging of the equipment shall be attached to the equipment and information regarding break down shall be passed to all staff including any shift changes	MO I/C	Nil
16	On restoration of the equipment, the equipment breakdown record should be updated. This indicates that the break down / maintenance is performed of the equipment. The Red Tagging sticker shall be removed after the restoration of equipments	MO I/C	Nil
17	All the break downs occurring in the departments should be maintained in the equipments register and include the following	MO I/C	Equipment register

	• Break down date and time • Breakdown details (Technical fault or other reasons) • Date and time of rectification • Total time taken (Rectification time – Break down time) • Rectification details with expenditure including cost (If any) • Remarks with functional status • Reasons for delay if any		

35. Process Efficiency Criteria:

S. No.	Key Performance Indicators	Benchmark/Standard/Target
1	Normal Delivery per 1000 delivery cases	
2	Proportion of deliveries conducted at night	
3	Proportion of complicated cases managed	
4	Proportion of assisted deliveries conducted	
5	Proportion of cases referred to higher facilities	
6	Percentage of newborns required resuscitation out of total live births	
7	Proportion of cases partograph maintained	
8	Episiotomy site infection rate	
9	No. of adverse events per thousand patients	
10	Proportion of cases of different complications(PPH, Eclampsia, Obstructed Labour etc.)	
11	No.of Maternal deaths out of total admission during ANC, INC, PNC	
12	Percentage of cases for which Maternal death Review done	
13	Percentage of JSY payments done before discharge	
14	Percentage of women provided drop-back facility after delivery	

36. Work Instructions

a) DO's & DON'T's

S.No.	Activity Instructions
01	**DON'T'S** Avoid unnecessary digital vaginal examination • Avoid prolonged Labour • Avoid artificial rupture of membranes unless necessary •Avoid routine episiotomies and other traumatic procedures like vacuum and forceps deliveries unless necessary • Avoid unnecessary suction of the new born. • use of external chappals
02	**DO'S**
	• In Labour ward all staff should always wear uniforms. • When conducting delivery, staff should put on goggles, apron and sterile gloves • Safely dispose sharp instruments, placenta, blood soiled dressing • Immediately wash your skin with soap and water or use water only if blood splashes on you or if it flashes into the eyes. • Use privacy curtains for every delivery table. • Check the delivery table mattress, bins conditions periodically. • Use only slippers dedicated to Labour room.
03	**Routine postnatal care done for all mothers** • Conduct appropriate infant feeding demonstration • Review infant feeding plan and provide appropriate support • Proper child hygiene including care of umbilicus • Proper hygiene for the mother including perineal care

(b) Work instructions for APGAR Score

The five criteria of the APGR Score

The Apgar score is determined by evaluating the newborn baby on five simple criteria on a scale from zero to two, then summing up the five values thus obtained. The resulting Apgar score ranges from zero to 10. The five criteria are summarized using words chosen to form a backronym (**A**ppearance, **P**ulse, **G**rimace, **A**ctivity, **R**espiration)

Sl. No.	Parameters	Score 0	Score 1	Score 2	Component of backronym
01	Skin color / Complexion	blue or pale all over	blue at extremities body pink (acrocyanosis)	no cyanosis body and extremities pink	**A**ppearance
02	Pulse rate	Absent	<100	≥100	**P**ulse
03	Reflex irritability	no response to stimulation	grimace/feeble cry when stimulated	cry or pull away when stimulated	**G**rimace

04	Muscle tone	none	some flexion	flexed arms and legs that resist extension	**A**ctivity
05	Breathing	absent	weak, irregular, gasping	strong, lusty cry	**R**espiration

37. <u>Indicators for Process Monitoring</u>

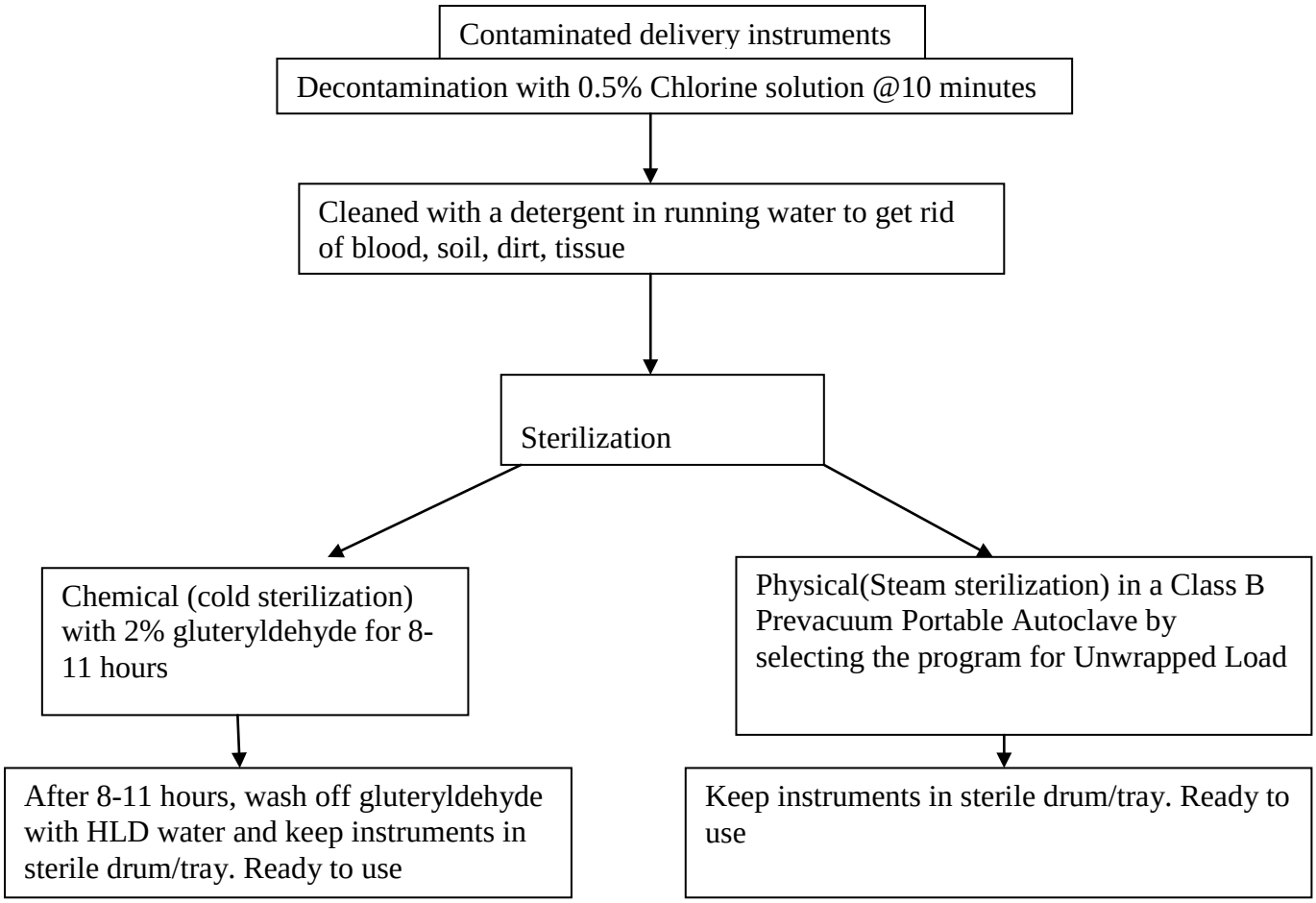
Sl. No.	Activity	Efficiency Criteria
01	Infant Mortality Rate/ Mother Mortality Rate	No. of infant/ mother dead x 100 ÷ No. of Total delivery
02	Percentage of mothers leaving hospital in less than 48 hrs.	no. of mothers leaving hospital in less than 48 hrs of delivery x 100 ÷ Total No. of delivery
03	Hospital Acquired Infection (HAI)	No. of cases of Post natal HAI within 42 days.
The above criteria are being calculated on monthly basis.		

38. <u>Reference Record</u>

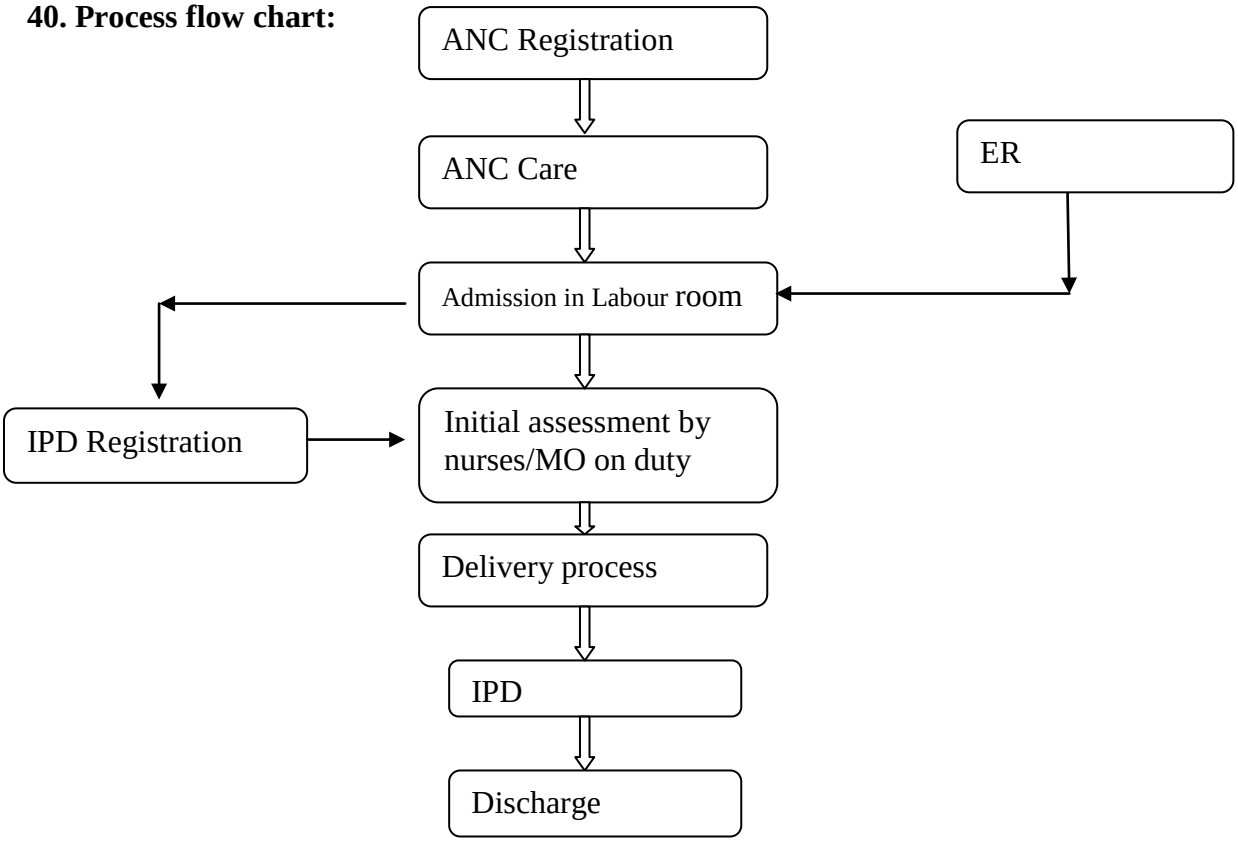
Sl. No.	Name of Records	Record No.	Location of Storage	Minimum Retention Period
1	LABOR ROOM REGISTER	PF-LR10-32	Labor room	
2	REFER IN REGISTER	PF-IP05-17	Nursing station	
3	REFER OUT REGISTER	PF-IP05-18	Nursing station	
4	REFERAL FOLLOW UP REGISTER	PF-RF06-94	Nursing station	
5	HOUSEKEEPING REGISTER BOOK	GA-H&G19-95	Nursing station	
6	NURSES DUTY ROASTER	GA-HR-84	Nursing station	
7	DAILY ADMISSION LIST	PF-IP05-21	Nursing station	
8	BIRTH REGISTER	Form-1(RBD Act 1969)	Nursing station	
9	NURSES REPORT BOOK/INPATIENTS NURSE'S RECORD	PF-IP05-96	Nursing station	
10	NASH AMBULANCE BOOK	GA-TR15-86	MO IC	

11	DIET BOOK	GA-SS-101	Nursing station	
12	LABOR ROOM INDENT REGISTER	GA-IM07-47	Nursing station	
13	HANDING OVER BOOK	PF-IP05-97	Nursing station	
14	BIOMEDICALWASTE MANAGEMENT REGISTER	GA-BMW13-75	Nursing station	
15	HIV/HBS.AG RAPID DAIGNOSTIC KIT	PF-LR04-40	Nursing station	
16	ABORTION REGISTER	PF-LR10-100	Nursing station	
17	HIGH RISK CASES REGISTER	PF-LR10-98	Nursing station	
18	IUD REGISTER	PF-LR10-99	Nursing station	
19	DEATH REGISTER	PF-MRD09-28	Nursing station	
20	LR SUB-STOCK REGISTER	GA-IM07-48	Nursing station	
21	INVESTIGATION FORMS FOLDER	PF-LR04-02	Nursing station	
22	STILL BIRTH REGISTER	Form-3 of RBD Act 1969)	Nursing station	
23	MATERNAL DEATH AUDIT FORMAT	GA-22-116	MO IC	
24	BED HEAD TICKET	PF-IP05-05	Nursing station	

39. <u>Flow Chart of Instrument Processing in the Labor Room</u>



40. Process flow chart:



16. Reference Documents

1. Guideline for pregnancy care and management of obstetrics complications for MO- MoHFW
2. SBA Guidelines for Antenatal Care and Skilled Attendance at Birth- MoHFW
3. Facility Based IMNCI- Participant Manual- MoHFW
4. Immunization Hand Book for Medical Officers- MoHFW
5. Maternal Death Review Guidebook – MoHFW
6. Operational Guidelines for JSSK
7. MTP Act 1972
8. Draft SOP NHSRC, QI Division MoHFW New Delhi.
9. MNH Toolkit

1.5.18