सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

DAKSHATA

Guidance for

MENTORING AND SUPPORT VISIT

MSV 4

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OBJECTIVE

The objective of this visit is to facilitate the process of ensuring the availability of all essential supplies, complete organization of labor room (LR), improved practice of processing of used instruments, and better record keeping. The mentor also needs to facilitate for essential skills-based practices and follow-up for completion of activities as planned in the action plan of previous visit.

DELIVERABLES OF MSV 4

Time since completion of training	Availability of drugs and supplies	LR organization	Adherence to IP and cleanliness protocols	Data recording and reporting	Essential practices training
2 months	Ensuring availability of all 61 items as per Dakshata Guidelines	Organizing drugs, supplies and medicines; Ensuring privacy of clients	Processing of used instruments	LR register	Partograph- with identification of obstructed and prolonged labor; Management of PPH

DESCRIPTION OF ACTIVITIES

Prepare

- Inform the facility/medical officer in-charge (MOI/c) at least one day in advance about the visit. Request time to have all relevant staff at one place for on-site training session.
- Ensure complete MSV 4 package and previous action plan of MSV 3 is available on the day of visit.
- Meet the MOI/c after reaching the facility and then proceed to LR.
- Carry few blank partographs and case studies for practice by staff.

Observe

Visit the labor room (LR) and complete the MSV sheet:

1. Physically verify the availability of 61 items as per Dakshata guidelines. Note any missing supplies and the level of bottleneck.
2. Observe whether the reorganization of LR done in previous visit is maintained. Also observe whether medicines and drugs are kept, and facility for birth companion is made available as per the guidance provided during previous visit.
3. Physically verify that the privacy of clients is maintained during her stay at the facility.
4. Check for the practice of processing of instruments as per protocol, physically verifying the availability of functional equipment required for the same.
5. Review 5 case records randomly to assess the status of completeness of the case sheets including the

safe childbirth checklist (SCC) and partograph. Also review the filled partographs and their interpretation by providers.

6. Review LR register to assess proper filling of different columns.
7. Observe care on any available client and assess:
   - Early identification of prolonged or obstructed labor by partograph and its' management, and
   - Early identification and management of postpartum hemorrhage (PPH).

Facilitate

Meet with the MOI/c, LR in-charge, and central store keeper to facilitate the following:

1. Availability of 61 supplies. Ensure that action plans are made with clear timelines and responsibility for supplies that can be ensured at the facility level. For supplies that need support from district, prepare plan with MOI/c.
2. Facilitate the continuation of the process of standardization of the labor room in line with the plan developed during previous visits. Ensure that the actions related to privacy of the clients and provisions for birth companions are complete.
3. Share the Government of India (GoI) protocol on processing of instruments with the MOI/c and LR in-charge and point out any areas of improvement.
4. Continue to emphasize the importance of using the case sheet, the SCC and the birthing register for ensuring availability of good quality data.

Train

Conduct an onsite training session to orient the labor room and other concerned staff on the following (using job-aids attached as annexures):

1. Importance of maintenance of privacy while performing any procedure for providing a respectful maternity care.
2. Processing of used instruments as applicable to the facility (Annexure l).
3. Completing partographs for monitoring the progress of labor. Discuss various components and help clear any doubts about any areas in these documents. Make the LR staff practice on filling of partograph and ensure correct interpretation for necessary and timely actions (Annexure II and III).
4. Essential practices
   - Initial management of prolonged and obstructed labor (Annexure IV).
   - Early identification and management of PPH (Annexure V). Demonstrate external aortic compression, bimanual compression, and balloon tamponade using mama natalie.

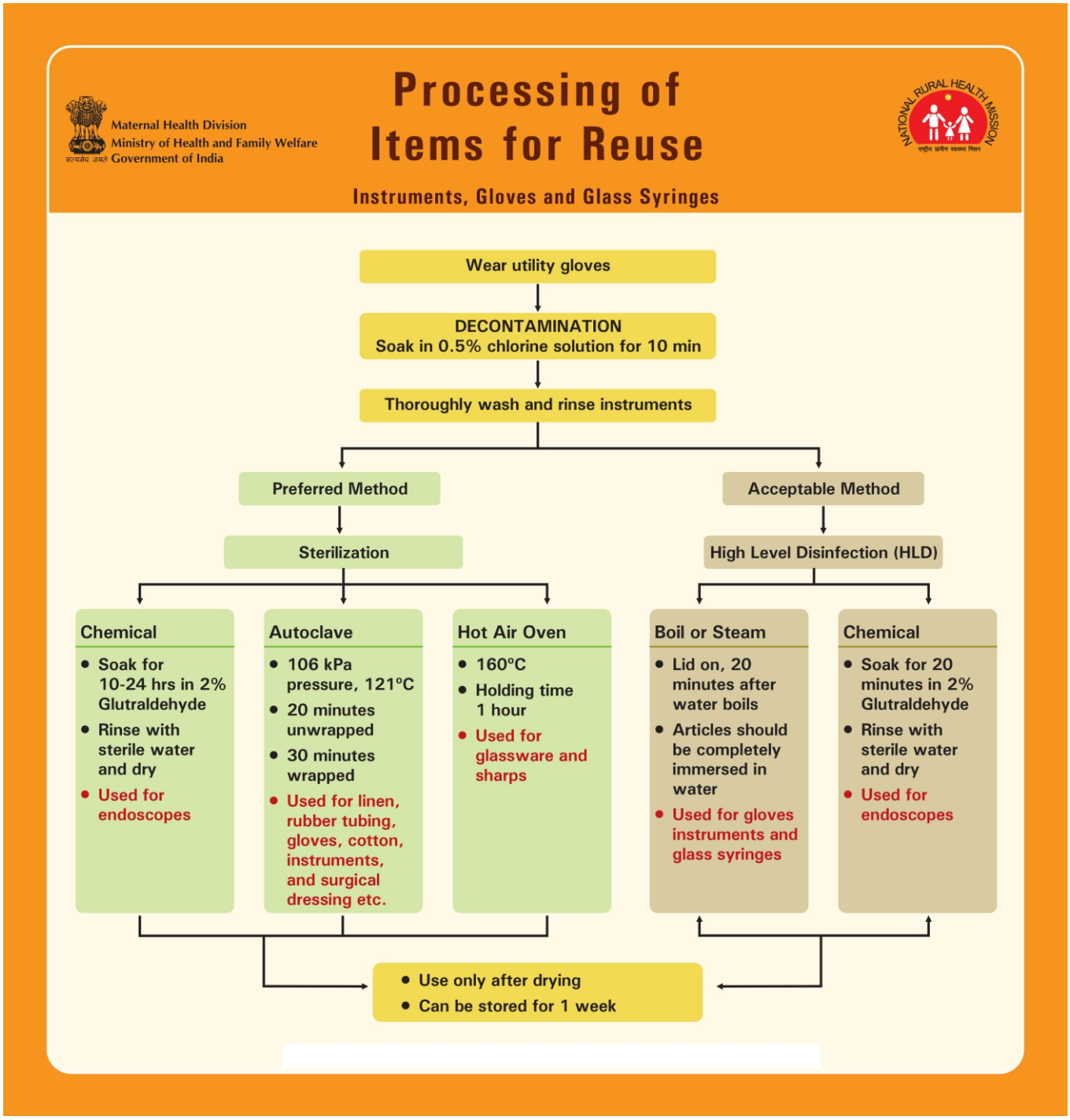
Action Plan Review

Review the action plan to see the status of activities since the last visit. Discuss timelines for pending activities and record timelines for new proposed activities.

Annexures

I.Processing of used instruments

A.GoI protocol on processing of instruments



THE SIMPLIFIED PARTOGRAPH

Identification Data

Name: W/o: Age: Parity: Reg. No.:

Date & Time of Admission: Date & Time of ROM:

A) Foetal Condition

Foetal heart rate: 200 190 180 170 160 150 140 130 120 110 100 90 80

Amniotic fluid

B) Labour

Cervic (cm) (Plot X): 10 9 8 7 6 5 4 — Alert — Action

Hours: 1 2 3 4 5 6 7 8 9 10 11 12

Time

Contraction per 10 min.: 5 4 3 2 1

C) Interventions

Drugs and I.V. fluid given

D) Maternal Condition

Pulse and BP: 180 170 160 150 140 130 120 110 100 90 80 70 60

Temp (°C)

Initiate plotting on alert line

Refer to FRU when ALERT LINE is crossed

Ministry of Health & Family Welfare
Government of India

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Guidance for applicability to facility

Interpretation

- If Alert line is crossed (the plotting moves to the right of the alert line) it indicates abnormal labor:prolonged/obstructed labor
- Note the time
- Refer patient to FRU
- Send partograph with patient
- Crossing of the Action line (the plotting moves to the right of the Action line): indicates the need for intervention
- By the time the action line is crossed the woman should ideally have reached the FRU for the appropriate intervention to take place

Indications for Referral

- FHR is <120 beats/min or >160 beats/min
- Meconium and /or blood stained amniotic fluid
- When cervical dilatation plotting crosses the alert line (moves towards the right side of the alert line)
- Contractions not increasing in duration, intensity and frequency e.g. 2 or less contractions lasting for <20 sec in 10 min

III.Case studies for partograph

CASE STUDY 1

Rani (wife of Rambhajan), 18 years of age, was admitted at 10:00 am on 11 June 2009 with complaints of labour pains since 7:00 am. This is her first pregnancy. Plot the following findings on the partograph:

At 10:00am:

- The cervix is dilated 4 cm. She had 2 contractions in 10 minutes, each lasting less than 20 seconds.
- The FHR is 140 per minute.
- The membranes are intact.
- Her BP is 100/70 mmHg.
- Her temperature is 37°C.
- Her pulse is 80 per minute.

10:30 am: FHR 140, contractions 2/10 each 20 seconds, pulse 90/minute
11:00 am: FHR 136, contractions 2/10 each 20 seconds, pulse 88/minute
11:30 am: FHR 140, contractions 2/10 each 20 seconds, pulse 84/minute
12:00 pm: FHR 136, contractions 3/10 each 30 seconds, pulse 88/minute, membranes ruptured, Amniotic fluid clear
12:30 pm: FHR 146, contractions 3/10 each 35 seconds, pulse 90/minute, amniotic fluid clear
01:00 pm: FHR 150, contractions 4/10 each 40 seconds, pulse 92/minute, amniotic fluid Meconium-stained
01:30 pm: FHR 160, contractions 4/10 each 45 seconds, pulse 94/minute, amniotic fluid Meconium-stained

At 2:00 pm:

- Cervix dilated 6 cm
- Amniotic fluid meconium-stained
- Contractions 4/10 each lasting 45 seconds
- FHR 162/minute
- Pulse100/minute
- Temperature 37.6°C
- BP 130/80 mmHg.

What action would you take in Rani's case?

CASE STUDY 2

Rubina (wife of Zarif), age 26 years, was admitted at 11:00 am on 12 June 2009 with the complaint of labour pains since 4:00 am. Her membranes ruptured at 9:00 am. She has three children, of the ages of 8, 7 and 2 years. She gave birth to a stillborn child four years ago.Plot the following findings on the partograph:

At 11:00 am:

- The cervix is dilated 4 cm.
- She had 3 contractions in 10 minutes, each lasting less than 20 seconds.
- The FHR is 140 per minute.
- The membranes have ruptured and the amniotic fluid is clear.
- Her BP is 100/70 mmHg.
- Her temperature is 37°C.
- Her pulse is 80 per minute.

11:30 am: FHR 130, contractions 3/10 each 35 seconds, pulse 88/minute, amniotic fluid clear
12:00 am: FHR 136, contractions 3/10 each 40 seconds, pulse 90/minute, amniotic fluid clear
12:30 pm: FHR 140, contractions 3/10 each 40 seconds, pulse 88/minute, amniotic fluid clear
01:00 pm: FHR 130, contractions 3/10 each 40 seconds, pulse 90/minute, amniotic fluid clear
01:30 pm: FHR 120, contractions 3/10 each 45 seconds, pulse 96/minute, amniotic fluid clear
02:00 pm: FHR 118, contractions 3/10 each 45 seconds, pulse 96/minute, amniotic fluid clear
02:30 pm: FHR 112, contractions 3/10 each 45 seconds, pulse 98/minute, amniotic fluid meconium-stained
03:00 pm: FHR 100, contractions 4/10 each 45 seconds, pulse 100/minute, amniotic fluid meconium-stained, temperature 37.8°C, BP 120/80 mmHg, cervix dilated 7 cm.
What action would you take in Rubina's case?

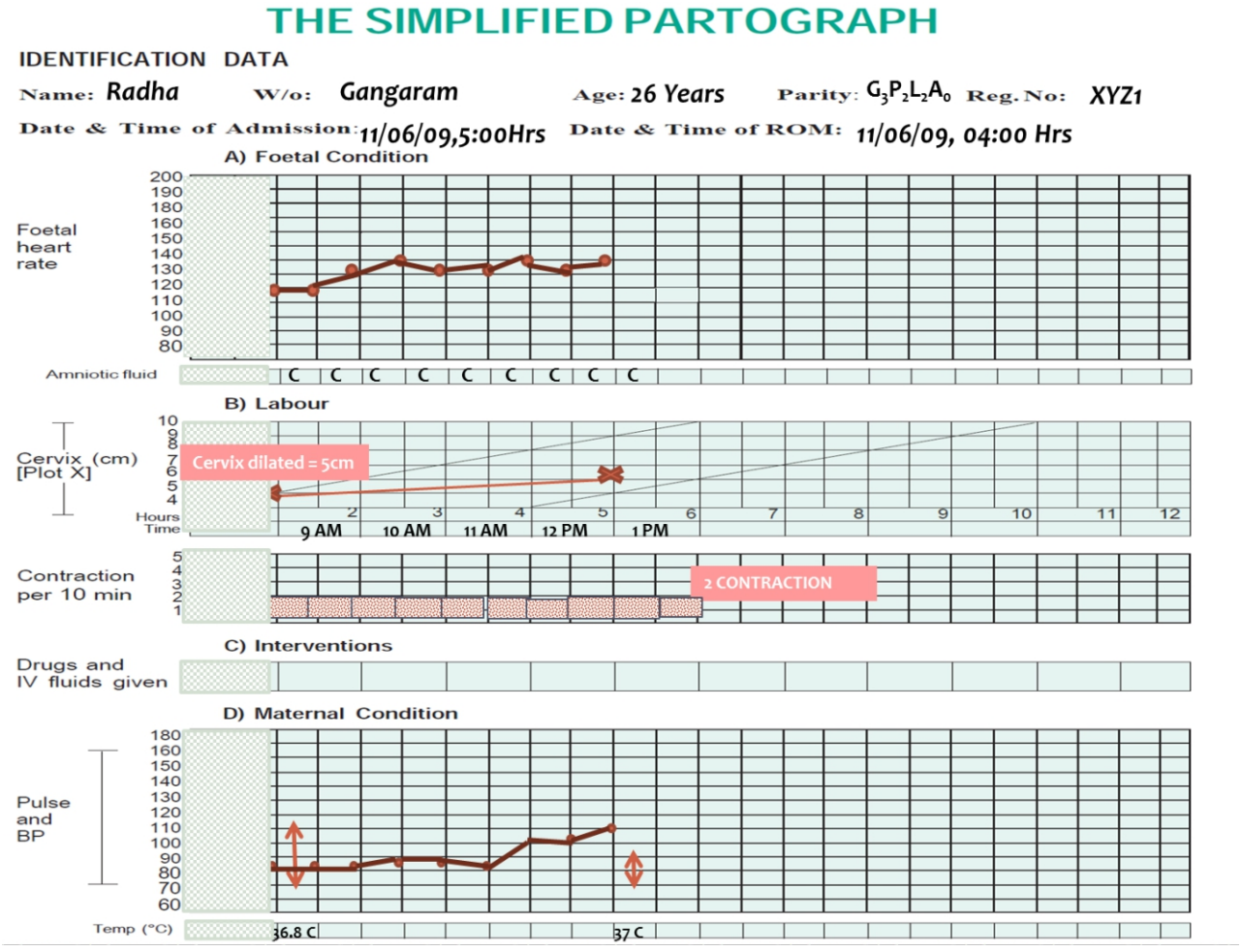
What action would you take in Rani's case?

IV.Prolonged and Obstructed Labor

A.Prolonged labor- Identification and Management

Prolonged Latent Phase	Woman is in true labor but her cervical dilatation has not progressed at all or has not reached 4 cm in 8 hours
Prolonged Active Phase	Woman is in active phase of labor (> =4 cm dilatation achieved) but cervical dilatation is not occurring at the rate of 1 cm/hour (overall should not last more than 12 hours)- cervical dilatation crosses alert line on partograph
Prolonged Expulsive Phase	Woman is in second stage of labor (> 10 cm dilatation achieved) but baby is not delivered for more than 2 hours even after the woman has an urge to push
Inadequate uterine activity	Means less than 3 contractions in 10 minutes, each lasting less than 40 seconds. Can occur anytime during active phase of labor. Can cause prolonged labor

Identification of prolonged labor through partograph

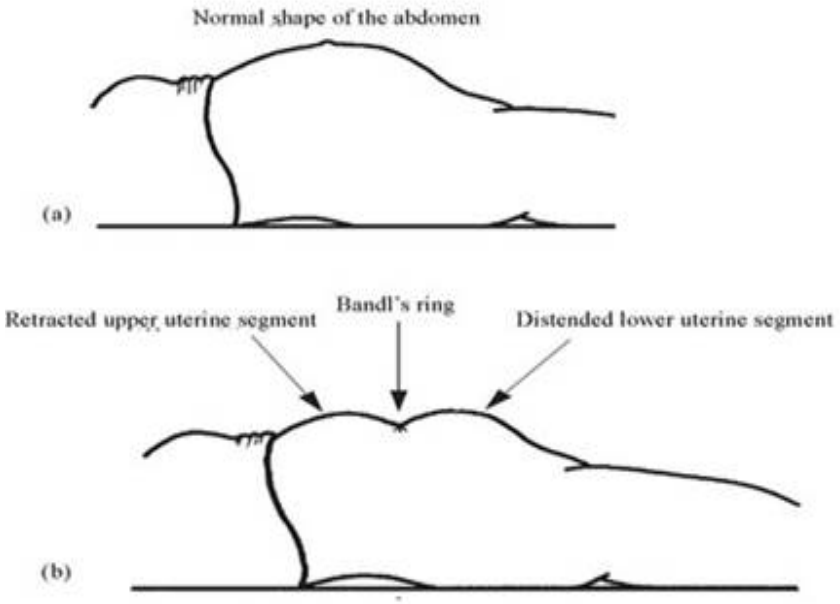


Management

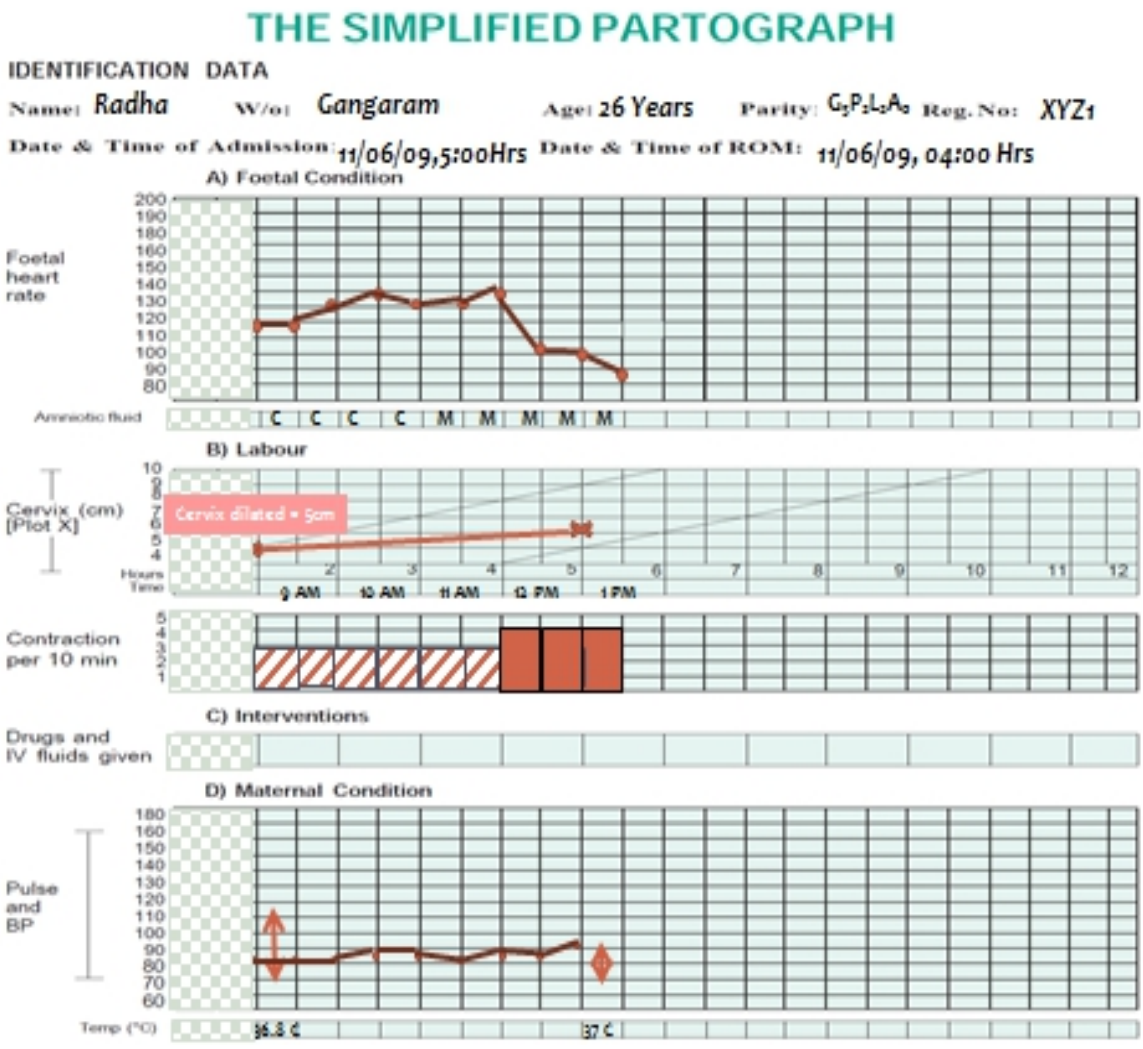
Woman is in active phase of labor (> =4 cm)	Initiate supportive care such as ambulation (in initial phase), maintaining hydration, emptying bladder and emotional support by birth companion.	Call obstetrician/EmONC trained doctor if available to assess and decide the course of action, or Refer the case to a higher center with facility of cesarean section if obstetrician/EmONC trained doctor is not available.
Prolonged Active Phase	Start filling partograph to monitor progress of labor. If the cervical dilatation crosses alert line and/or fetal heart rate shows fetal distress, follow next column.	
Prolonged Expulsive Phase	Monitor fetal heart rate, contractions and descent of head. If delivery of baby does not happen within two hours of full dilatation of cervix or there are signs of fetal distress, follow next column.	
Inadequate uterine activity	If woman is having less than 3 contractions in 10 minutes, each lasting less than 40 seconds.	Call obstetrician/EmONC trained doctor for decision on augmentation of labor (if cesarean facility is available), else refer to higher center
In all cases of prolonged labor, give one dose of antibiotics before referral- Inj. Ampicillin 1 gm IV after sensitivity testing, Inj. Gentamicin 80 mg IM, Inj. Metronidazole 500 mg IV		

B. Obstructed labor- Identification and Management

Findings on general examination	Physical and mental exhaustion, dehydration, ketoacidosis, fever, shock due to ruptured uterus or sepsis
Findings on vaginal examination	Foul smelling meconium, drained off amniotic fluid, vulval edema, hot and dry vagina, large caput
Findings on fetal evaluation	Fetal distress or absent fetal heart sound
Findings on abdominal examination	• Fetal head above pelvic brim • Women may have frequent & strong contractions or they may have stopped due to uterine inertia or rupture of the uterus. • Bandl's RING may be seen at area between upper and lower uterine segments when it becomes visible/ palpable. Depression across the abdomen at the level of umbilicus • Shape of uterus looks like a peanut shell



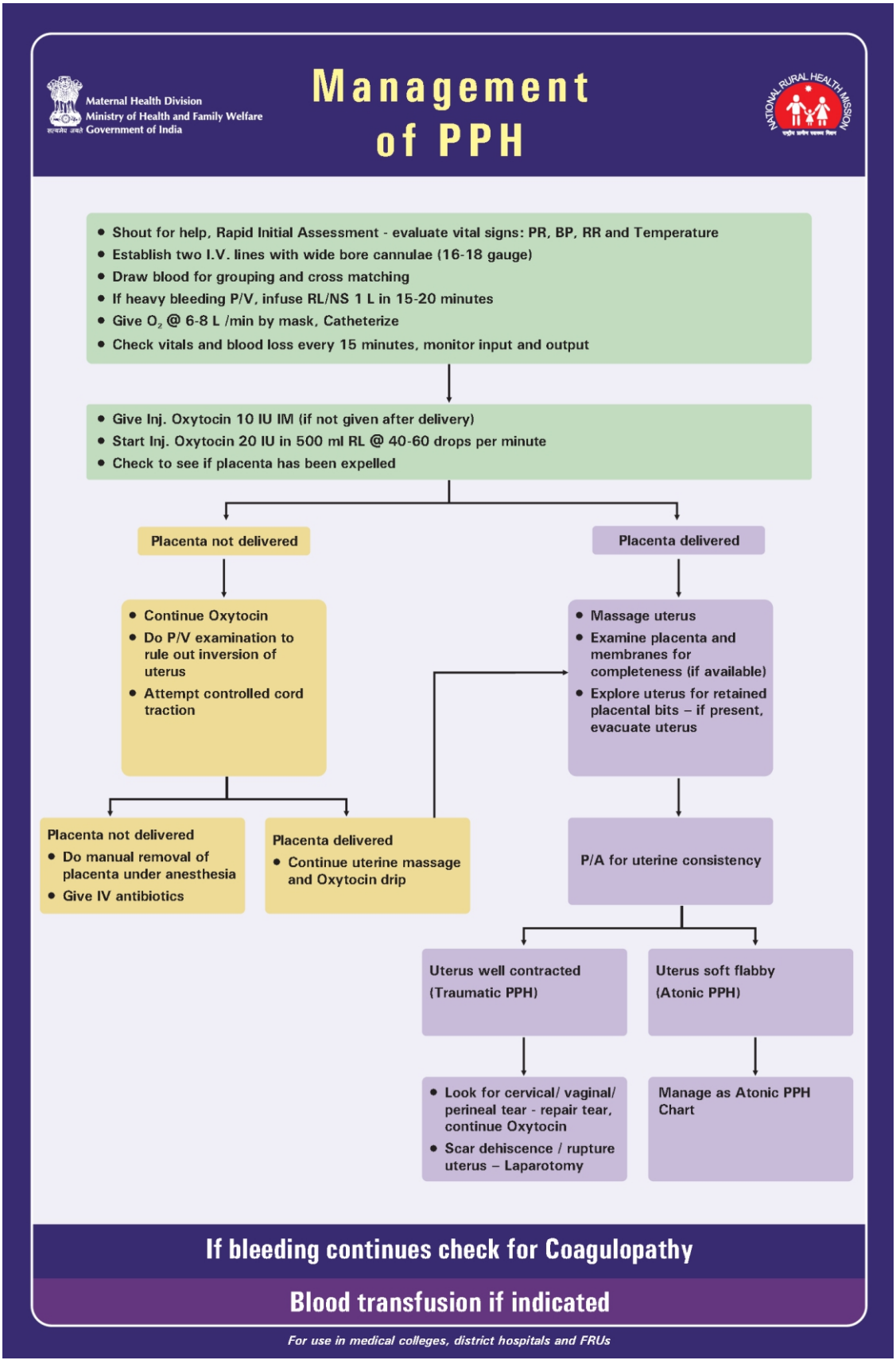
Identification of obstructed labor through partograph

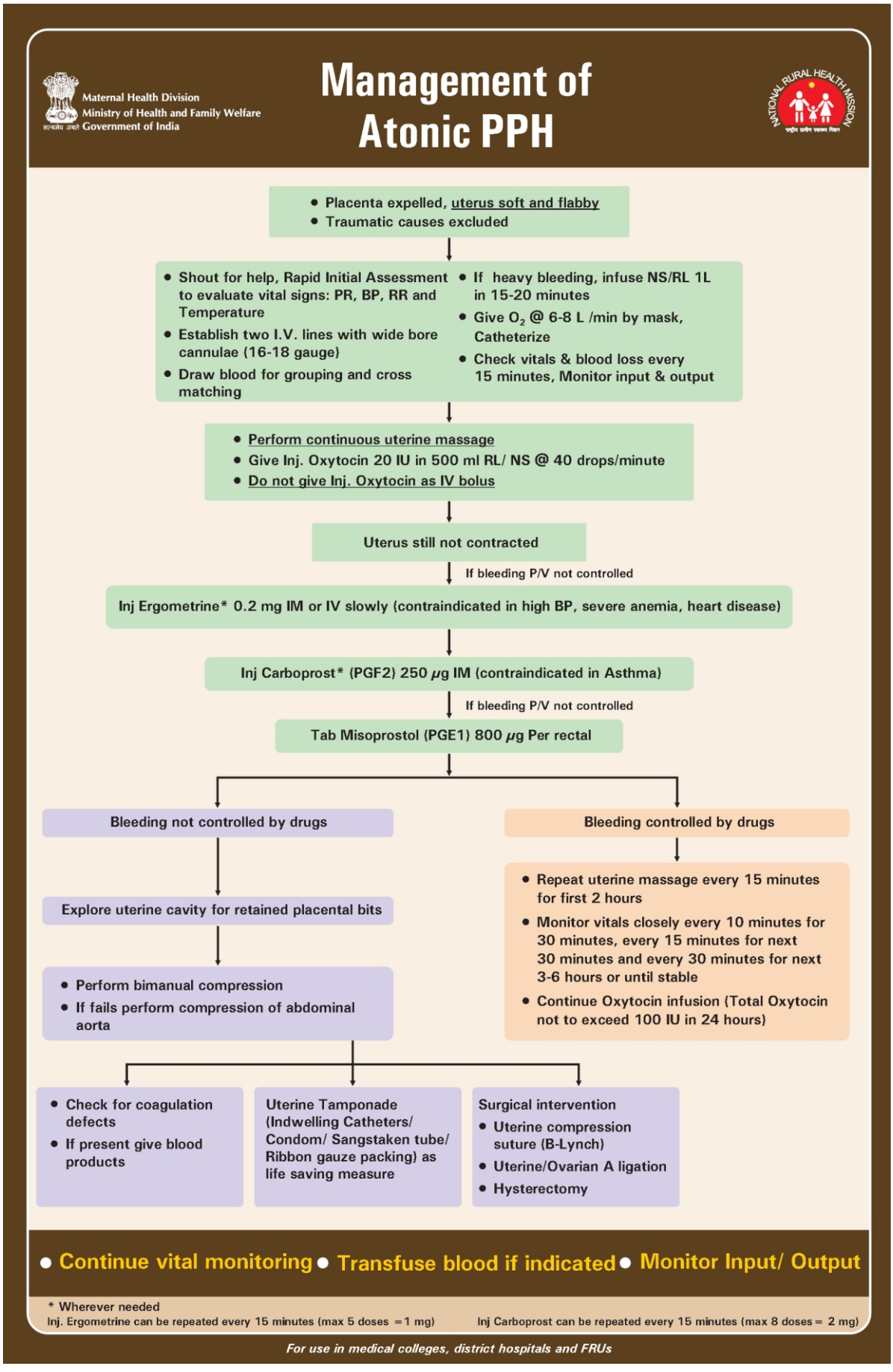


Management

- Rehydrate the patient- Start and IV line R/L or normal saline @ 25-30 drops/min
- Give antibiotics- Inj. Ampicillin 1 gm IV after sensitivity testing, Inj. Gentamicin 80 mg IM/IV, Inj. Metronidazole 500 mg IV
- Refer the patient to FRU for cesarean section

V.GoI protocol for management of PPH




Maternal Health Division
Ministry of Health and Family Welfare
Government of India
Management of Atonic PPH
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• Placenta expelled, uterus soft and flabby
• Traumatic causes excluded
• Shout for help, Rapid Initial Assessment to evaluate vital signs: PR, BP, RR and Temperature
• Establish two I.V. lines with wide bore cannulae (16-18 gauge)
• Draw blood for grouping and cross matching
• If heavy bleeding, infuse NS/RL 1L in 15-20 minutes
• Give O_2 @ 6-8 L /min by mask, Catheterize
• Check vitals & blood loss every 15 minutes, Monitor input & output
• Perform continuous uterine massage
• Give Inj. Oxytocin 20 IU in 500 ml RL/ NS @ 40 drops/minute
• Do not give Inj. Oxytocin as IV bolus
Uterus still not contracted
If bleeding P/V not controlled
Inj Ergometrine* 0.2 mg IM or IV slowly (contraindicated in high BP, severe anemia, heart disease)
Inj Carboprost* (PGF2) 250 µg IM (contraindicated in Asthma)
If bleeding P/V not controlled
Tab Misoprostol (PGE1) 800 µg Per rectal
Bleeding not controlled by drugs
Explore uterine cavity for retained placental bits
• Perform bimanual compression
• If fails perform compression of abdominal aorta
Bleeding controlled by drugs
• Repeat uterine massage every 15 minutes for first 2 hours
• Monitor vitals closely every 10 minutes for 30 minutes, every 15 minutes for next 30 minutes and every 30 minutes for next 3-6 hours or until stable
• Continue Oxytocin infusion (Total Oxytocin not to exceed 100 IU in 24 hours)
• Check for coagulation defects
• If present give blood products
Uterine Tamponade (Indwelling Catheters/ Condom/ Sangstaken tube/ Ribbon gauze packing) as life saving measure
Surgical intervention
• Uterine compression suture (B-Lynch)
• Uterine/Ovarian A ligation
• Hysterectomy
• Continue vital monitoring • Transfuse blood if indicated • Monitor Input/ Output
* Wherever needed
Inj. Ergometrine can be repeated every 15 minutes (max 5 doses = 1 mg)
Inj Carboprost can be repeated every 15 minutes (max 8 doses = 2 mg)
For use in medical colleges, district hospitals and FRUs