सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

DAKSHATA

Guidance for

MENTORING AND SUPPORT VISIT

MSV 5

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OBJECTIVE

The objective of this visit is to facilitate the process of ensuring the availability of all essential supplies, strengthening of adherence to infection prevention practices including processing of instruments, introduction of dash board indicators, adherence to essential skill-based practices and record keeping. Additionally, the mentor will review the action plan of previous visit for follow-up of completion of activities.

DELIVERABLES OF MSV 5

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
3 months	Ensuring availability of 61 items as per Dakshata guidelines	Continue LR standardizatio n, Ensure completion of actions related to ventilation and lighting	Processing of used instruments	LR register; Dashboard	Monitoring 4th stage of labor; Identification of management of HIV delivery cases; Care of babies with Small Size at Birth; Discharge counselling

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.
- Carry the, mama breast, preemie natalie and the KMC wrap for demonstration of care for babies with small size at birth.
- Ensure complete MSV 5 package and previous action plan of MSV 4 is available on the day of visit.
- Meet the facility in-charge after reaching the facility and then proceed to LR.

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. Note down any remaining action from plan of action of the standardization of labor rooms.
3. Check for the practice of processing of instruments as per protocol.
4. Physically verify the availability of functional equipment for sterilization or high level disinfection (HLD).
5. Review LR register to assess proper filling of different columns.
6. Physically verify the availability of HIV diagnostic kits, anti-retroviral therapy (ART) and syrup nevirapine in LR.
7. Observe care on any available client (mother and newborn) under immediate postpartum observation in LR, in the postpartum ward, and at time of discharge, and assess:

- Duration of keeping the mother and newborn in LR after delivery and frequency of monitoring them during the 4th stage of labor,
- Early initiation of breastfeeding,
- Special care provided to babies with small size at birth, for thermal management and assisted feeding,
- Safe delivery practices for HIV positive cases, and
- Discharge counselling for mother and newborn to the family as per protocol.

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 facility level. For supplies that need support from district, prepare plan with MOI/c.
2. Review the remaining actions related to the LR standardization with the MOI/c. Help prepare action plan with clear timelines for these remaining actions.
3. Review the action plan from the previous visit related to the processing of instruments and facilities for sterilization of reusable equipment.
4. Review the case sheets, SCC, and birthing registers to ensure that the staff continues to complete these important tools.
5. Share with MOI/c, LR in-charge, and LR staff the list of dashboard indicators as applicable to the facility.

Train

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

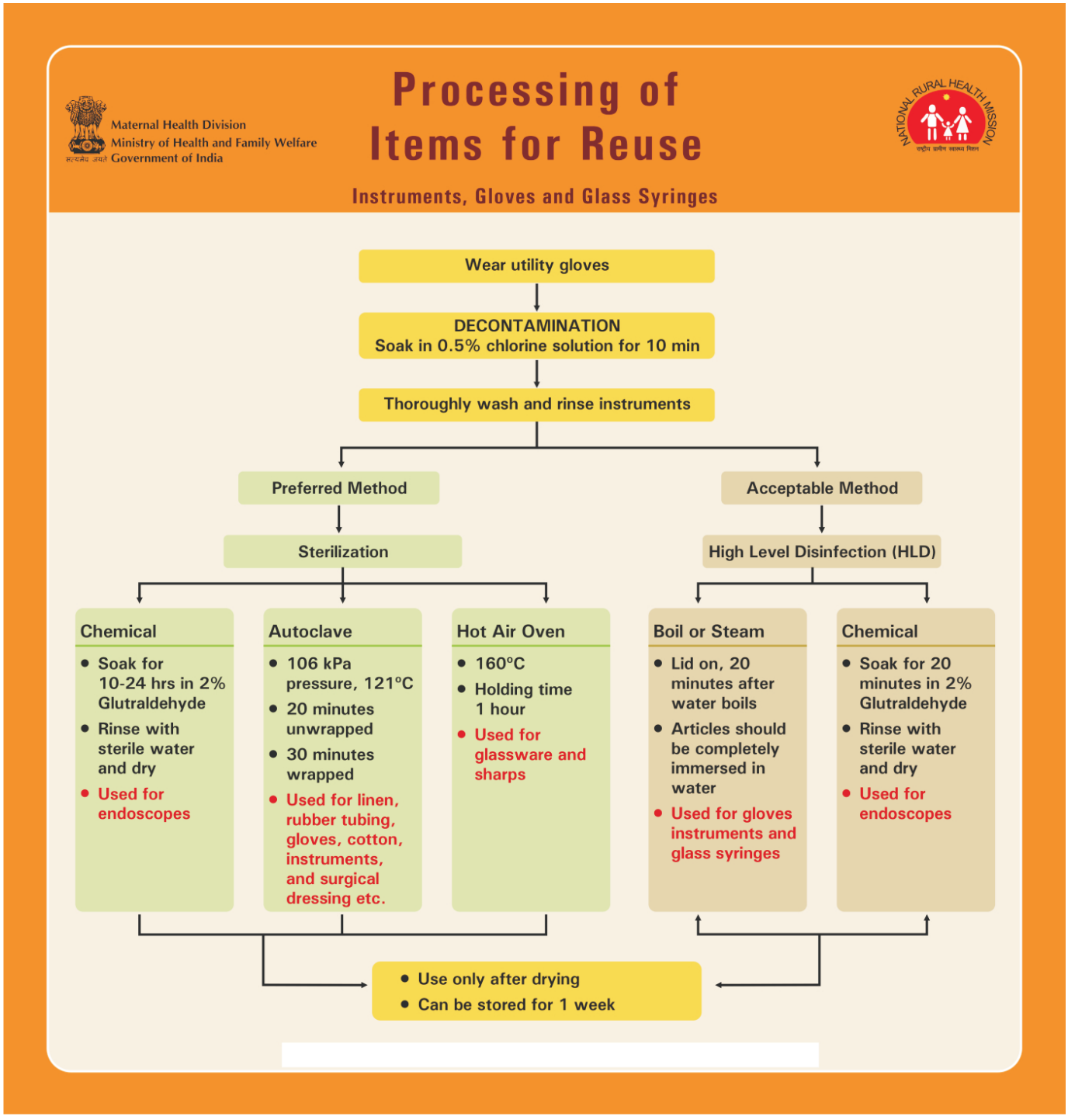
1. Re-emphasize the importance of processing instruments after each use (Annexure I). Review action plans for sterilization and preparation of instrument trays with the relevant staff.
2. Filling of LR register- clear any doubts and reiterate on the importance of completeness of LR records.
3. Importance of data reporting on the dashboard indicators and review subsequently for planning necessary actions. Train health workers on the importance of monitoring each indicator.
4. Essential practices
    - Monitoring 4th stage of labor- review of postpartum care of mother and newborn and early initiation of breast feeding as per protocol (Annexure II). Use mamabreast to demonstrate correct attachment, position of the baby and technique of breast feeding. Demonstrate expression and storage of breast milk.
    - Identification and management of HIV positive cases including safe birth practices to be followed (Annexure III).
    - Care of babies with small size at birth- thermal management such as kangaroo mother care (KMC) and assisted feeding (Annexure IV). Use preemie natalie and KMC wrap to demonstrate KMC and orogastric feeding tube insertion.
    - Discharge counselling for mother and baby as per protocol (Annexure V).

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.Protocol for processing of used instruments



II.Care of mother and baby in 4th stage

A. Monitoring of condition of mother and newborn

For Mother	For Baby
Check the mother every 15 minutes for the following (for 2 hours) for A. General condition, BP and pulse B. Uterus, whether well-contracted or not C. Perineum and vagina for amount of vaginal bleeding, conditions of suture or any swelling/ hematoma **Encourage woman** A. To maintain hydration B. To Initiate breastfeeding within half an hour C. To understand importance of colostrum feeding D. To not to give any pre-lacteal feed to baby **Explain** Danger signs to mother and companion (refer to SCC)	**Care of Newborn within 1-2 hours after Birth** **Assess** A. Respiratory Rate B. Chest in drawing, grunting C. Body temperature **Look** A. Baby' color B. Baby's cry and activity C. Any congenital malformation D. Birth injury E. Umbilicus for any bleeding

Timely Identification and Management of Complication

- Be watchful for appearance of signs of any complications such as PPH,
- Eclampsia/Pre-eclampsia based on the periodic assessment of mother's condition
- Manage complications as per protocols

Maternal Health Division
Ministry of Health and Family Welfare
Government of India

Breastfeeding

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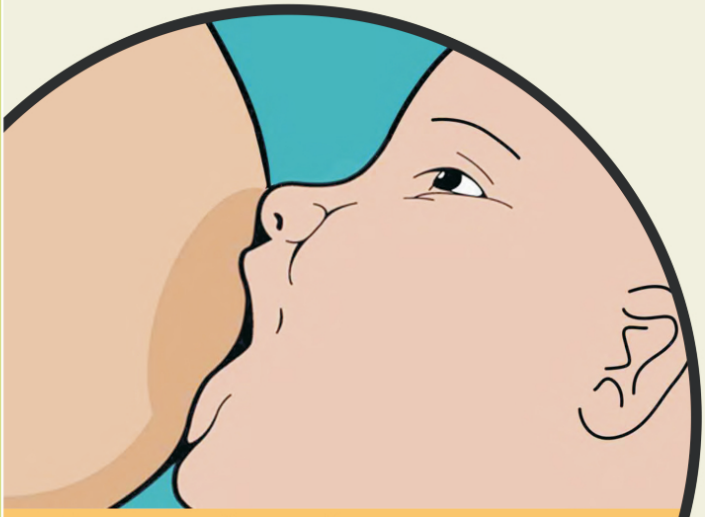
- Start breastfeeding within 1 hour of delivery
- Feed on demand
- Feed completely on one breast, then shift to other breast

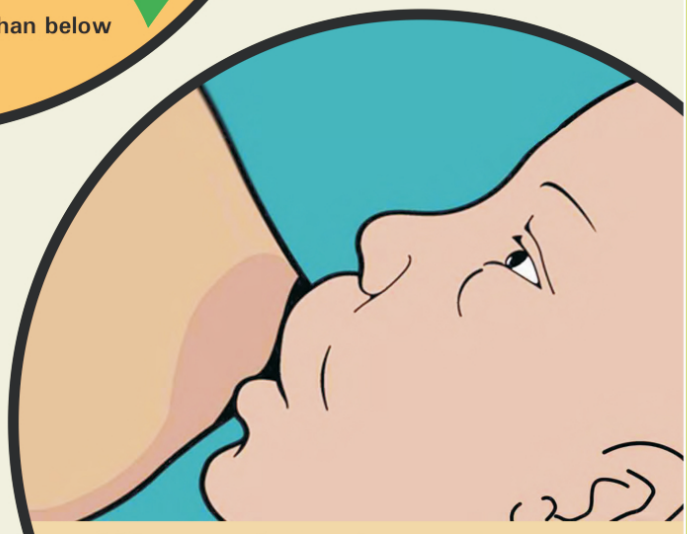


Correct Attachment

Baby well attached to the mother's breast

- Chin touching breast
- Mouth wide open
- Lower lip turned outward
- More areola visible above than below the mouth

Exclusive breastfeeding for 6 months; continue breastfeeding for 2 years



Wrong Attachment

Baby poorly attached to the mother's breast

For use in medical colleges, district hospitals and FRUs

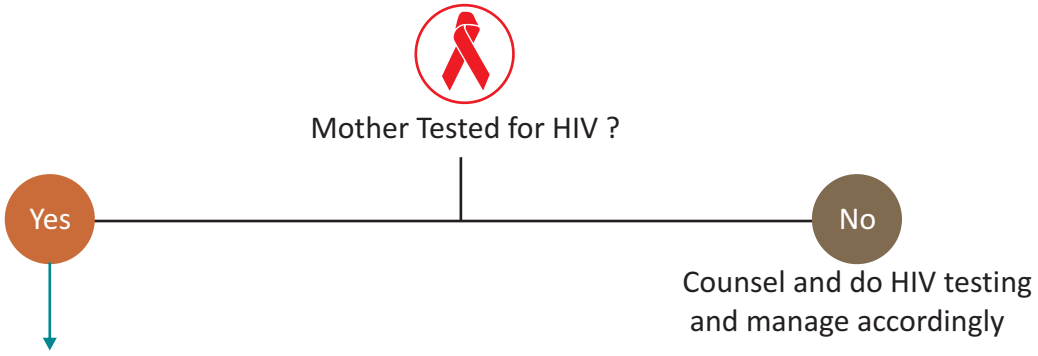
III. Management of HIV positive cases in labor room

Prophylaxis for mother and newborn

Prescribed regimen for newly diagnosed or not on ART cases

For Mother	For Baby
Tenofovir (TDF) 300 mg + Lamivudine (3TC) 300 mg + Efavirenz (EFV) 600 mg once daily	**For newborn** Infants born to HIV-infected mothers should receive syrup nevirapine immediately after birth to be continued till 6 weeks irrespective of breast feeding status (extended to 12 weeks of syrup Nevirapine if the duration of the ART of mother is less than 24 weeks)

HIV Status and Use of ART



Already on ART	Continue lifelong ART irrespective of CD4 counts after admission
Not on ART	Start triple drug regimen irrespective of CD4 counts or clinical stage as a life long therapy
If ART is not available at the facility	Refer to the centre with Integrated Counselling and Testing Center (ICTC) facility for delivery. If delivery is imminent, conduct delivery following Universal Precaution and refer to ART center after delivery

Birth Weight of infant	Dose(mg)	Dose(in ml)	Duration
Birth Weight >2.5 Kg	15mg once daily	1.5mg once daily	Upto 6 weeks irrespective of exclusively breast fed or exclusive replacement fed
Birth Weight >2Kg to <2.5kg	10mg once daily	1mg once daily	
Infants with birth weight<2Kg	2mg/kg once daily	0.2mg/kg once daily	

Safe Delivery Techniques in HIV+ Pregnant Women

Observe the following in HIV+ woman:

- Standard/Universal Work Precautions (UWP)
- DO NOT rupture membranes artificially (ARM)
- Minimize vaginal examination and use aseptic techniques
- Avoid invasive procedures like fetal blood sampling, fetal scalp electrodes
- Avoid instrumental delivery
- Avoid episiotomy
- DO NOT perform routine suctioning of newborn

IV.Care of babies with small size at birth

A.Kangaroo mother care (KMC)

PREPARATION FOR KMC

COUNSELLING & DEMONSTRATION FOR KMC

KMC POSITION

WHO CAN PROVIDE KMC (FATHER AND OTHER RELATIVES)

Guidance for applicability at facility

Eligibility criteria for KMC:

- All LBW babies
- Sick hemodynamically stable babies needing special care (even those on IV Fluid or on Oxygen)

The two components of KMC are:

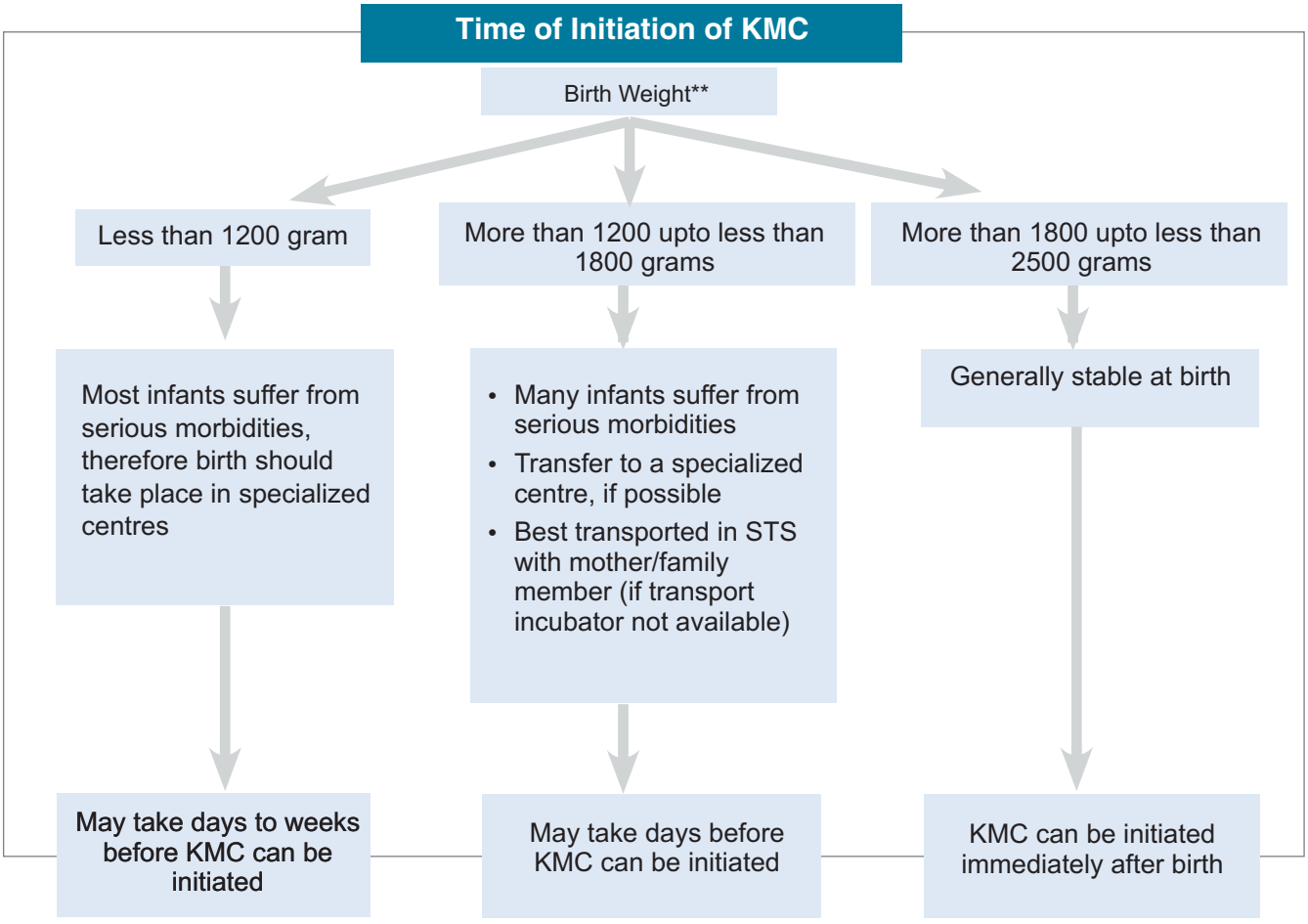
- Skin-to-skin contact
- Exclusive breastfeeding

The two prerequisites of KMC are:

- Support to the mother in hospital and at home
- Post-discharge follow up

Benefits of KMC:

- Reduces risk of hypothermia
- Promotes lactation and weight gain
- Reducing infections and hospital stay
- Better bonding between mother and newborn



B. Technique for expression of breast milk

Source: Facility Based Newborn Care Operational Guide, MoHFW, Government of India

C.Assisted feeding- by orogastric/nasogastric (OG/NG) tube

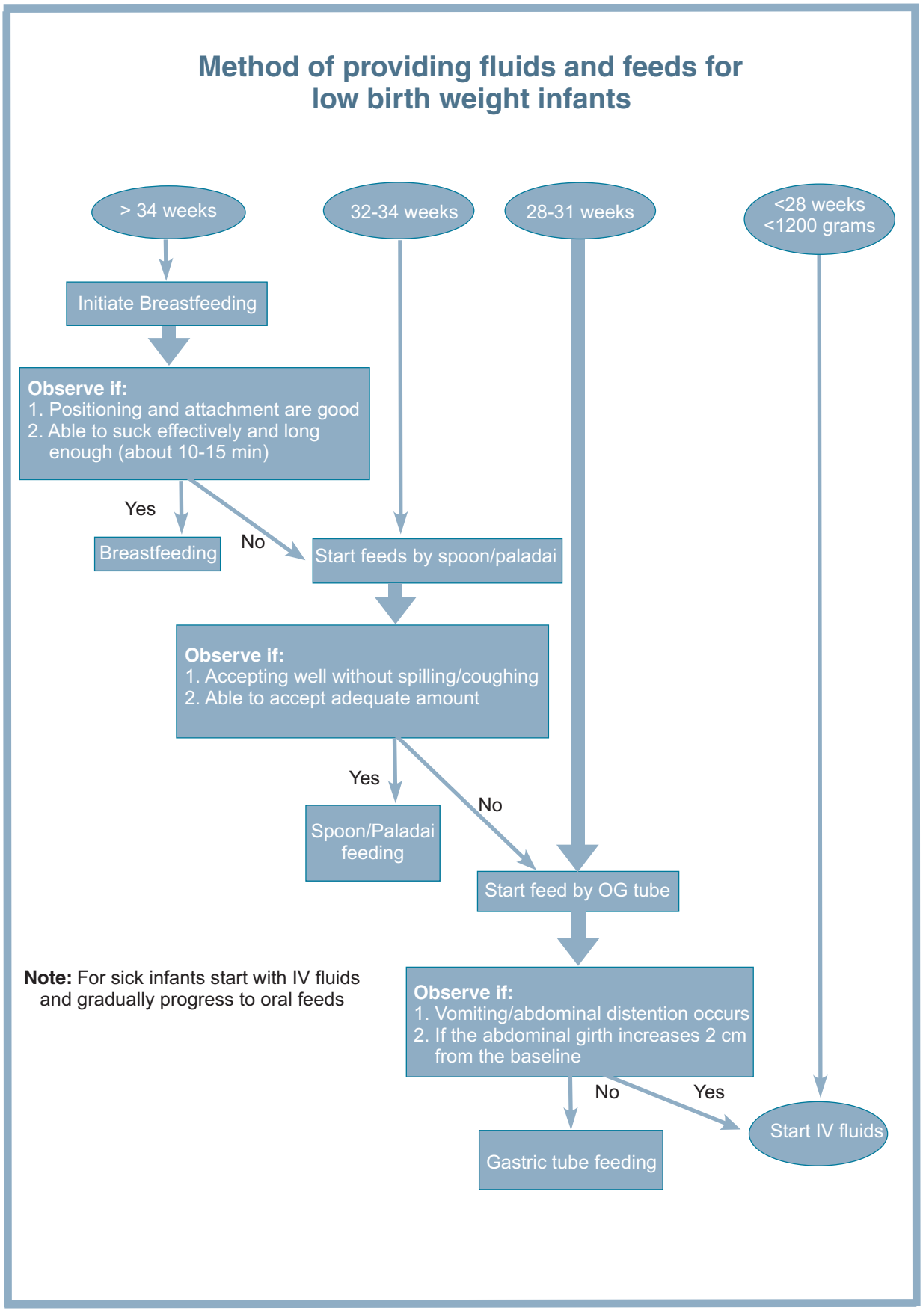
S.N.	Steps for insertion
A.	**Getting ready/supplies:** • Sterile/clean examination gloves • Clean orogastric (OG)/nasogastric tube (6F or 8F) • Writing pen or flexible tape measure • 2-5 mL syringe (for aspiration) • Sterile 10mL syringe (for feeding) • Cap of gastric tube • Kidney dish or bowl • Pediatric stethoscope • Scissors • Normal saline • Adhesive tape
B.	**Procedure for insertion**
1.	Arranges necessary supplies
2.	Washes both hands, air dries and wears sterile/clean examination gloves on both hands
3.	Measures required length of tube without removing it from its sterile packet. Notes the point of graduated marking from the angle of mouth or the tip of nostril to the lower tip of the ear lobe and then to the mid-point between the xiphisternum and umbilicus (this corresponds to the point just below the rib margin). Notes this length and marks the tube at this point with a pen
4.	Elevates the baby's head to flex the baby's neck slightly, holds the tube at least 5 -6 cms from the tip with the remaining tube in the package for no-touch technique of insertion
5.	Moistens the tip of the tube with normal saline and gently inserts it through the mouth or through one nostril pointing towards the back of throat to the required distance
6.	Confirms correct positioning of the tube ¾ Aspirates some fluid or ¾ If no aspirate, then places a stethoscope just below xiphisternum slightly to the left side of the upper abdomen. Attaches a syringe having 2-3 cc air, auscultates with a stethoscope for sound of gush of air in the stomach when all the air is pushed. ¾ If no sound heard, withdraws the tube immediately by kinking it and re inserts it once again ¾ Removes the syringe and closes the OG tube hub with the stopper (for next feed) or leaves it open (if it is for gastric distension)
7.	Secures tube in place gently with tape on the cheek and records point of its insertion in cms at the angle of mouth/nostril before each feed
C.	**Feeding with OG tube**
1.	Washes hands properly

S.N.	Steps for insertion
2.	Takes the required amount of feed (breast milk) in a clean bowl
3.	Ensures the tube is in the stomach by noting its point of measurement at the angle of mouth and cross-checks it with the records
4.	Attaches the appropriate size syringe for feeding (10 mL or more) without its plunger to the OG tube
5.	Keeps the syringe vertical, pours the required amount of milk in the syringe and allows the feed to go down slowly with gravity
6.	Pinches the tube when the syringe is empty to prevent the passage of air, removes the syringe and closes the hub of the tube
7.	Disposes the syringe in the red bin or processes it for next use by decontamination for 10 minutes, washing and either HLD or sterilization
D.	**Procedure for removal**
1.	Gently removes adhesive tape after wetting it
2.	Pinches and gently pulls out the tube to prevent spilling or aspiration of contents in the trachea
3.	Disposes the tube in the red bin after cutting it. To re-use, decontaminates in 0.5% chlorine solution for 10 minutes, washes and does HLD or sterilization

Key points

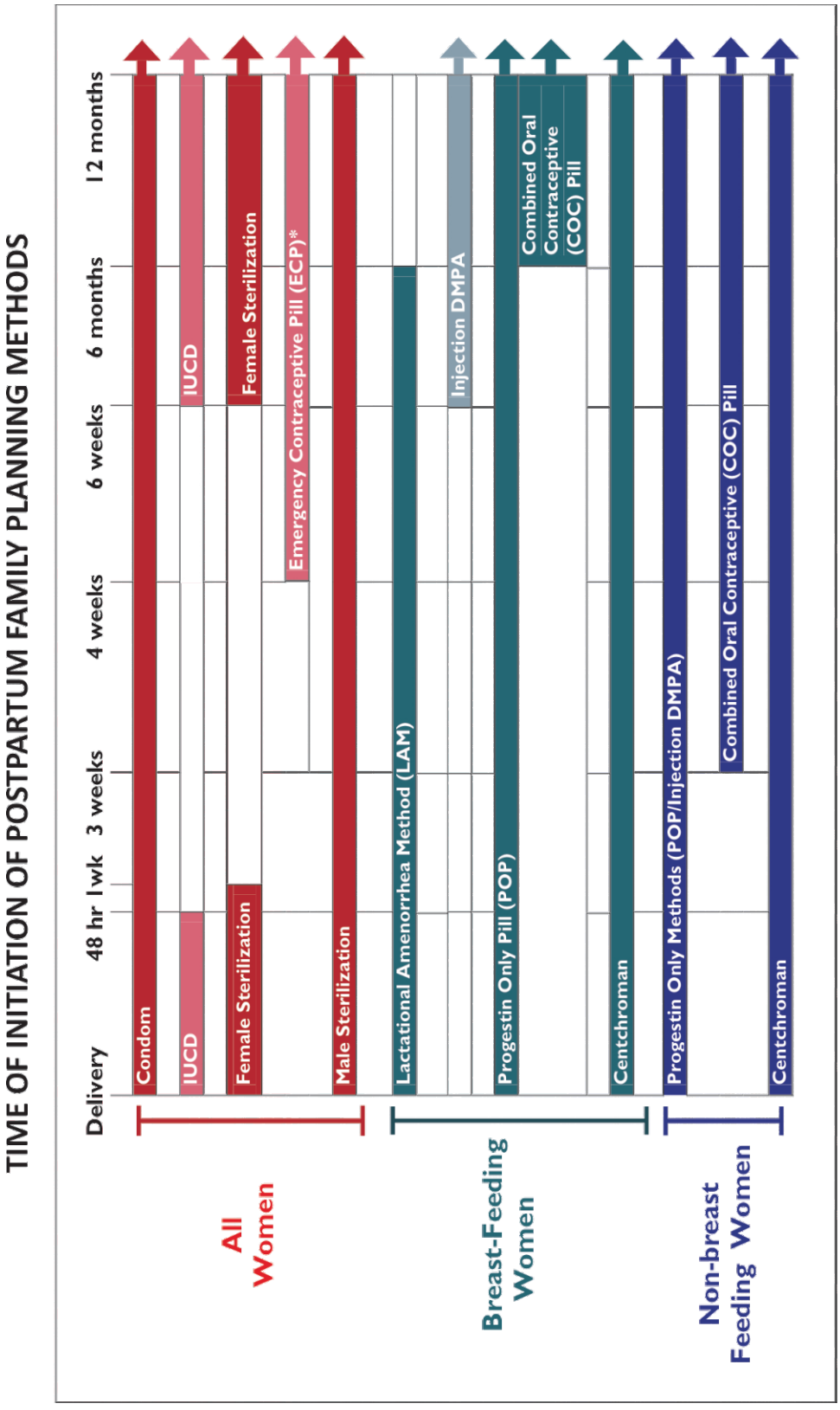
- **Indications:** Feeding sick, preterm baby or low birth weight babies who cannot suck; gastric drainage in babies with abdominal distension or neonates with congenital or surgical conditions like duodenal atresia
- Feeding tube size 8F (2.70 mm) for babies >1500gms and 6F for babies <1500gms
- While inserting the tube, observe closely for breathing difficulty and colour changes. If the baby develops difficulty breathing or turns blue or vomits, remove the tube immediately as it may be in the trachea. Always pinch the tube before removing
- If resistance is felt during insertion, do not push further. Remove the tube and retry or call for assistance
- While feeding do not push the milk in the syringe with its plunger, let it go slowly with gravity
- Insertion of orogastric tube is preferred over nasogastric tube in a newborn baby
- If gastric tube is inserted for drainage, leave the tube uncapped and wrap clean gauze around the end, fix with tape to keep the tube clean and absorb the drainage from the stomach

D.Methods of feeding



V.Discharge counselling for mother and baby

A.Family planning counselling



* This is to be used only in emergency. For a regular contraceptive use, take advice from ANM/Doctor at government health centre.

B.Counselling on DANGER SIGNS at time of discharge

Mother	Baby
• Excessive bleeding • Severe abdominal pain • Severe headache or visual disturbance • Breathing difficulty • Fever or chills • Difficulty emptying bladder • Foul smelling vaginal discharge	• Fast/difficulty breathing • Fever • Unusually cold • Stops feeding well • Less activity than normal • Whole body becomes yellow