सत्यमेव जयते

NATIONAL HEALTH MISSION
राष्ट्रीय स्वास्थ्य मिशन

DAKSHATA

Guidance for

MENTORING AND SUPPORT VISIT

MSV 7

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OBJECTIVE

The objective of this visit is to facilitate the process of ensuring availability of all supplies, organization and disinfection of labor room (LR), onsite capacity building of health workers through emergency drills, record keeping and review through dashboard indicators with a follow-up for completion of activities as planned in the action plan of previous visit.

DELIVERABLES OF MSV 7

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
5 month	Ensuring availability of 61 items as per Dakshata Guidelines	Ensuring LR organization as per previous MSVs	Protocols as per previous MSV	Dashboard indicators used for review	Emergency drill on conducting normal delivery, AMTSL and 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 drill.
- Carry all essential models and supplies for conducting the drill.
- Ensure complete MSV 7 package and previous action plan 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. Assess the status of standardization of LR in line with the national guidelines.
3. Assess the adherence to protocols for LR cleaning, LR entry, instrument processing, as established during the previous visits.

Facilitate

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

1. By this visit, all drugs and supplies necessary as per Dakshata guidelines should have been made available at the facility. Discuss the issue at district or state level (as applicable), if the gap remains unresolved at facility level administration.
2. Discuss action plans with clear timelines and responsibility for supplies that can be ensured at the

facility level. For supplies that need support from district, prepare the plan with MOI/c.

3. Review the plans for infrastructure upgrade and discuss responsibilities.
4. Share the finding of your assessment of adherence to the protocols for cleanliness, instrument processing, sterilization, entry into LR, etc. and discuss areas in need for intervention.
5. Review of dashboard indicators to track the progress and for necessary action planning based on identification of gaps.

Drill

The objective of an emergency drill is to:

- Assess and improve facility preparedness for managing basic and emergency obstetric situations,
- Objectively assess the translation of learned MNH skills in to practice in a non-threatening environment,
- Build capacity of health staff for early identification of warning signs and their timely and appropriate management,
- Streamline the communication and clinical decision making system in facility teams,
- Help facilities induct system level changes to create a quality enabling environment.

Conduct an emergency drill on conducting normal delivery, AMTSL and PPH, as per Annexure I.

Action Plan Review

1. Review the action plan to see the status of activities since the last visit.
2. Discuss the observations from drill exercise on coordinated team effort to manage the emergency situation, and scope for improvement, as applicable.
3. Document this feedback at the facility level and plan for a reorientation on gaps identified in the essential skills of LR team, if needed.
4. Record new proposed activity with clear timelines and person-specific responsibilities.

Annexures

Important things to consider before the simulation exercise (preparation):

- Simulation drill exercises can be done in two ways – with or without prior information to staff.
- The facility in-charge should be informed in advance regarding the visit and its purpose without giving them any information about the clinical situation which will be managed to avoid any type of bias.
- The availability of facility service delivery team should be insisted during the exercise. If in case, availability of one or more key facility team members could not be ascertained, then alternative arrangements like telephonic availability should be requested. If it is not possible to ascertain the availability of key staff then appointment for different timings should be sought.
- It is expected that the facility to be visited will have all the required logistics available by this time.

The procedure for conducting simulation drills in the facility should be followed under three heads as mentioned below:

1. Before the exercise
2. During the exercise
3. After the exercise

1.Before the exercise

A.Briefing of facility in-charge and the Facility Team (FT) on the simulation drill exercise

A meeting of all the staff engaged in childbirth related care should be arranged on pre-decided date and time. Availability of the facility in-charge should be insisted for this meeting. The FT should be first informed of the objectives of the meeting/exercise. It should be explained to the team that this exercise is not a critical evaluation of their facility's functioning, but an exercise for their own understanding of their preparedness status for managing a complication. It will also be helpful for them in identifying the key gaps and subsequently bridging them.

Subsequently the process of the simulation should be explained to the FT members. Any question from the FT members should be answered. The mentor should make sure that all the facility team members understand the procedure, and are ready to play their respective roles in the care provision. Essentially, every team member is supposed to play the role they normally play for the care of a pregnant woman and a newborn in the facility.

Ideally the facility processes and status of supplies should remain as is, in order to have an effective learning experience for the FT. This should be communicated to the team at the time of briefing. However, if any team insists on reorganizing the facility or making any changes in the protocols before the initiation of the exercise, they should be allowed to do so and same should be discussed later on.

If possible and resources permit, the permission for video recording the exercise should be sought from facility in-charge to enable the team to review the care provision process and identify key areas for improvement. The recording will also help in giving crisp feedback when the exercise is over.

B.Introduction of standardized client and the observer team

Standardized client and the observers should be introduced to the facility team. It should be emphasized to the FT that observer and instructor are not to be considered present for all practical purposes. The instructor will prompt the key findings for which they are assessing the client. For example, if they are assessing the client for BP, the instructor will prompt the recordings like 160/110.

1.During the exercise

The exercise starts with arrival of the client and her attendant in the facility, where the FT receives, assesses and manages the client as per their understanding and facility protocols. During this process, the observers should record their observations of facility performance and standardized client clinical outcomes on a standard observation recording sheet. During the simulation, the facility team should perform examinations, assessments, and maneuvers on the standardized client short of actual invasive procedures. For example, for recording FHR they should use a method - fetoscope, stethoscope, or fetal Doppler; for BP measurement they should tie the cuff of the BP apparatus on the arm of the standardized client; they should prepare syringe/vacutainers, stillette for pricking without actually pricking the standardized client. Since the standardized client uses a Mama Natalie/appropriate model during the exercise, the team members may also perform any vaginal procedure such as a PV. On performing such action, the observer should provide the result of the procedure or test to the team. For example, if the care provider completes the process of setting up the BP cuff around arm, the observer should prompt the BP value for the woman. Similarly, for any medication, the FT members should actually hand over any oral medicine to the standardized client. For any IM/IV drug, they should break the ampoules, fill up the syringe with appropriate doses, and act as if they are injecting the medicine, stopping short of actually injecting it. For starting an IV line also, the care provider should set up the IV set, and stop short of actually putting the IV line in the client.

The standardized client and her attendant may also try to create pressure situation and panic within the facility team to see the system level challenges.

The outcome of the simulation drill will be successful when the facility team appropriately manages the case and saves the life of mother and/or the baby, or unsuccessful when the team is unable to manage the client as per the recommendation even after reasonable time. Whatever the situation is, the mentor should conclude the drill exercise, and congratulate and thank the team for their participation. It needs to be ensured that all the relevant formats are being filled during the exercise for the purpose of documentation and giving feedback to the facility.

If possible, observer/mentor should record the whole procedure after taking due permission from facility in-charge to facilitate discussion later during debriefing meeting.

3.After the exercise

After completing the drill exercise, mentor should congratulate the team and organize a feedback meeting with the facility team. Following schema should be observed to give crisp and constructive feedback:

A.Debriefing

After the completion of the drill, mentor should sit with the staff to discuss on following points:

a) Good practices and congratulate
b) Main outcome of the task and completion of the task within time
c) Coordination or team work ability
d) Standard achievements

If time allows, drill video that was captured should be shown raising questions like:

a) What should have been done better?
b) What was not done right?

Mentor should never forget to correct the mistakes and discuss the main outcome of the exercise.

B.Re-run exercise (if required and time permits)

It is recommended that, the facility team should be allowed to complete one practice drill on the same case scenario, and is hoped that this time they will perform better. However, the observers/mentor should handhold and support the team members in successfully performing essential practices to prevent or manage complications. The same methodology should be used by the care givers for simulating tests, procedures, and medication as that for the assessment simulation.

Case Scenario: CASE WITH NORMAL DELIVERY BUT RESULTING IN PPH

Geeta 21 year old gravida 2 para 1 presents at full term in labor with the onset of contractions approximately 6 hour ago. She is a booked case with history of regular ANC check-ups. Her records indicate she is carrying a singleton pregnancy in the vertex presentation. Her past medical history is uncomplicated, she has no allergies, and she takes no medications other than supplements. Her prenatal labs tests are within normal limits and her pregnancy has been uncomplicated.

Observation	Yes	No	Prompts for the observer/standardized client	Instruction for standardized client	Remarks
Provider elicits relevant obstetric, medical and surgical history and reviews relevant medical records					
History of presenting complaints elicited and recorded				Pain in abdomen	
Relevant menstrual history elicited and recorded				9 months back	
Relevant obstetric history elicited and recorded				G2P1, rest of the obstetric history - nothing significant	
Relevant medical history elicited and recorded				Not significant	
Relevant surgical history elicited and recorded				Not significant	
Provider reviews investigation records			Hb, urine and others – within normal limits, HIV –ve, single fetus, vertex presentation, no cephalo pelvic disproportion		
Provider conducts general physical examination					
BP recorded			110/70		
Temperature recorded			98^0 F		
Pulse			84/min		
Pallor, edema			Absent		
RS, CVS, CNS examination done			No significant findings		

Provider conducts per abdominal examination					
Providers palpates abdomen			Full term, cephalic presentation, contractions – 4 contractions per 10 minutes, each lasting more than 40 sec		
Provider auscultates to elicit fetal heart rate			FHR – 140/min		
Provider conducts per vaginal examination					
Provider washes hands before doing PV examination using correct technique					
Provider wears gloves in both hands					
Provider followesproper technique of conducting PV examination			Cervical dilatation – 5 cms, 80% effaced, head at 0 station, membranes present		
Partograph plotting started			Rate of cervical dilatation is satisfactory, no fetal distress and all the maternal parameters are normal		
Preparation for conducting the delivery - labor room organization (can also be observed later on)					
PPE available and provider wears them correctly (except gloves at this stage)					
Provider washes hands before doing PV examination using correct technique					

Provider wears sterile gloves using proper technique					
Provider switches on the radiant warmer/heat source at least half an hour prior to delivery					
Provider prepares delivery tray and bay tray					
Provider prepares newborn care corner with all essential equipment and supplies					
Provider loads uterotonic prior to conducting the delivery					
Was the client shifted to LR at appropriate time					
Provider conducts the delivery as per the facility specific protocols					
Provider placed two pre-warmed towels on mother's abdomen				Slowly start pushing the baby out	
Provider cleans perineum using proper technique (apply nothing on model)					
Episiotomy done*					
Provider provides perineal support				Keep pushing the baby out	
Head flexion done				Push the head of the baby out	
Suction of baby after delivery of head done*					
Assisted the delivery of shoulders and body				Push the baby out completely	
Baby received on the mother's abdomen			Baby is crying normally		

Active Management of Third Stage of Labor (AMTSL) with ENBC					
Provider rules out the presence of second baby					
Provider dries the baby rapidly with a clean dry towel from head to feet, discards the used towel/sheet and covers the baby including the head with a clean dry towel/Puts a cap					
Provider assesses the baby for breathing, color of extremities and muscular tone					
Provider applies identification band on baby's wrist or ankle					
Provider performs delayed cord clamping: clamps & cuts cord by sterile instruments within 1-3 minutes of birth					
Provider places the baby in skin-to-skin contact on the mother's chest or abdomen					
Provider initiate breast feeding within 1 hour of delivery				Start breatfeeding	
Provider gives injection vitamin K and records birth weight of baby			Baby weight- 3 Kgs		
Provider delivers the placenta by CCT				Deliver the placenta	
Provider receives the palcenta on a receiver					
Provider gives Uterine massage			Uterus relaxed	Start bleeding	
Placenta properly examined and appropriately disposed			Placenta and membranes are complete without any anomalies		

Proper examination of perineum, cervix and vagina done			Continuous bleeding, Uterus relaxed, No tears		
Management of PPH(Atonic PPH)					
Provider identifies the case of PPH				Continue bleeding	
Provider calls for help					
Provider continues uterine massage					
Provider establishes two IV line			IV line in place	Show symptoms of shock	
Blood grouping &cross matching done			Done		
Provider starts rapid infusion of NS/RL					
Provider adds 20 IU of oxytocin to 1000 ml of Ringer lactate/normal saline IV at the rate of 40–60 drops per minute Uterine massage continued simultaneously			Injection Oxytocin 10 IU, intramuscular stat which has already administered during AMTSL)		
Provider evaluates vital signs			SBP < 90 mmHg, Pulse > 110/min, RR > 30/min, skin cold and clammy, woman anxious and confused		
Provider gives oxygen (if available)					
Provider keeps the client in head low position, Keeps patient warm					
Catheterization done (self-retaining catheter)					
Arrange for blood			Bleeding continues, vitals stable, uterus relaxed		

Provider decides to refer the pt.			Conclude		
Or, started other uterotonic, started bi-mannual compression and started or decision made for utilization of other mechanical compression method or surgical intervention made			Conclude		
Check for labor room organization at the facility					
Baby warmer/heat source available					
Delivery tray prepared and ready to use					
Baby tray prepared and ready to use					
Provider follows correct technique of wearing gloves					
4 color coded bins available					
Hub cutter and puncture proof box available					
0.5% chlorine solution available					
For mother • Delivery tray prepared along with followings • 2 perineal pads • 2 artery clamps • 1 bowl with gauze pieces for antiseptic cleaning • Sponge holder • Scissors for cord cutting • Episiotomy tray prepared • Uterotonic (to be used immediately after delivery)					
Receiver for placenta available					

For essential newborn care – check for availability of • Two pre-warmed clean towels • Cord ligature/clamp • Mucus extractor • Cap for baby • Identification band • Vit K1					
For NBR at NBC area – check for availability of • Radiant warmer/heat source • Shoulder roll • Mucous extractor • Bag and mask (Size 0, 1) • Oxygen supply • Stethoscope • Working clock with second's hand					

•This checklist has some common harmful practices mentioned. Those have been kept for sole purpose of observing them. This checklist should never be considered as a client management protocol as it include both good as well as harmful practices