Inodaya Hospitals

INODAYA HOSPITALS, KAKINADA

OBSTRETRIC & GYNAECOLOGY MANUAL

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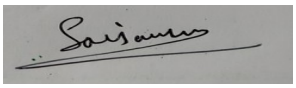
Prepared By & Responsibility of Updating :	**Dr.S. Satya Soujanya (OBG & Gyn)** **Sign:** 
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AMENDMENT SHEET

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➢ OBSTETRICS AND GYANECOLOGY

➢ Purpose

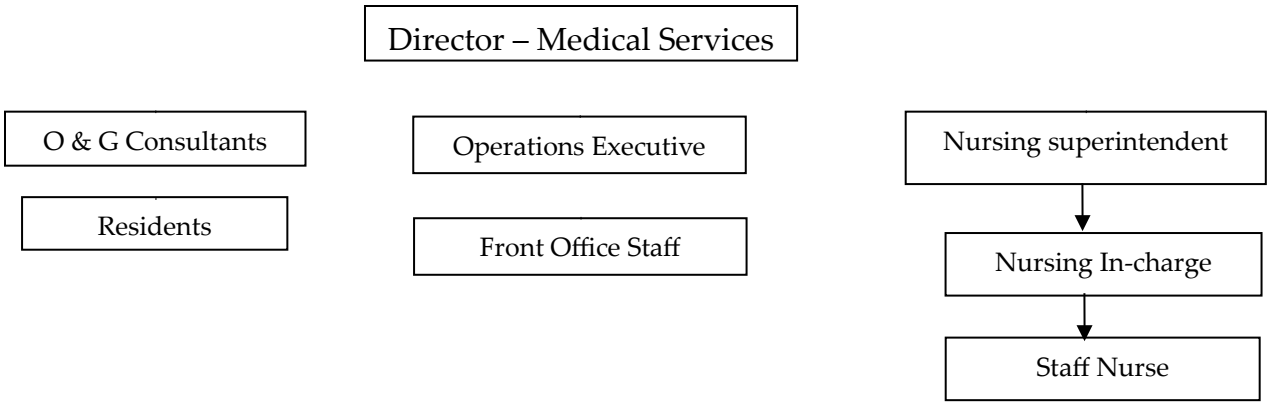
To provide the best possible care to the patients in Obstetrics and Gynaecology

➢ Scope

The procedure covers:

1) Outpatient care: Evaluation by consultants in the outpatient and management.
2) Inpatient care: Admission in the wards and special rooms.
3) Referrals to the department from consultants.
4) Emergencies - All Obstetric and Gynaecological emergencies.

➢ Departmental Hierarchy



➢ Job Responsibilities

a. Consultants

They have the overall responsibility for the evaluation and treatment of patients seen in the department, both outpatients and inpatients. Has the responsibility for the investigations, procedures, surgeries, deliveries conducted, treatment, daily monitoring of progress and ultimate discharge after treatment.

b. Residents

They work under the guidance of the consultants and carry out the care of the inpatients including - daily detailed rounds, maintain progress of the patients, assist the consultant in the labour room and operation theatre.

They have also to manage emergencies in the department - round the clock.

They prepare detailed discharge summary of the patient which will be approved by consultant.

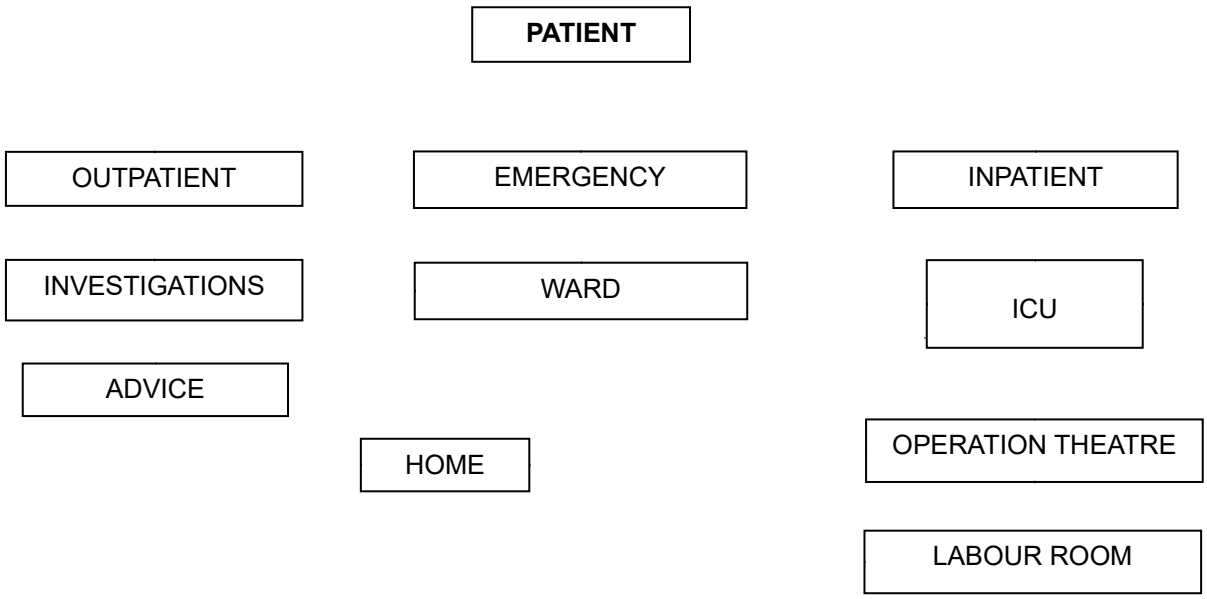
c. Nursing Staff

Routine general and special nursing care whenever needed. Assist doctors in the operation theatre and labour room.

d. Auxiliary Nurse / Midwives

In the labour room - assist in deliveries and work under the guidance of the doctors and nurses, also take care of the patient in labour, and babies in the neonatal unit.

➢ Flow Process



➢ Procedure

Outpatient Care

The cases are seen by the consultants during their stipulated hours. After registration at reception consultant examines and evaluates them. It includes detailed present and past history (Obstetric and Gynaecological) followed by general and Gynaecological / Obstetric examination. Investigations are ordered. This includes lab and ultrasound examination. PAP smear is taken for the gynaecological patient. Antenatal packs of investigations are carried out for the pregnant woman which includes:

(a) Complete blood picture
(b) Complete urine examination
(c) Blood Group and Rh type
(d) Blood VDRL, blood sugar,
(f) Screening for HbSAg, HIV I & II, HCV

(g) Obstetric ultrasound and special investigations wherever necessary depending on the previous obstetric History. After investigations the patient is received with reports and treatment is advised and regular monitoring of the progress of pregnancy and proper records are maintained. When needed - Referral to the consultants is made, in cases of cardiac patients, the diabetic woman, the hypothyroid patient etc if a procedure or surgery is planned. When the "Booked "pregnant woman goes into labour, she reports to the labour room with her records.

Inpatient Care

Gynaecological procedures: In elective surgical cases the patient is admitted one day prior to the surgery. The various surgical operations performed include

a) Hysterectomies - Routine abdominal, vaginal, laparoscopic assisted hysterectomies,
b) Laparoscopic, diagnostic and therapeutic, tuboplasty (infertility)
c) Tubectomy
d) Medical termination of pregnancy
e) Family planning advice - the procedure done is explained in detail to the patient.

Routine Surgical profile of investigations is done which includes complete blood picture, complete urine examination, blood group & Rh type, screening for HBsAg, HIV I & II, HCV, bleeding & clotting time, Blood Urea, random blood sugar & serum Creatinine, X- ray chest, ECG, ultrasound of abdomen including pelvis.

- Pre-op anaesthetic check up is done by the Anaesthetist.
- Routine pre-op detailed, written instructions are given by the residents & consultants with regard to the preparation of the patient for surgery.
  The necessary consent is taken for surgery from patient.
- Surgery: Procedure described in the operation theatre, performed by the consultant & assisted by Residents and operation theatre staff nurse.
- The patient is kept in the recovery room attached to the O.T & then shifted to the ward/room. If critical case is required patient is kept in the I.C.U's where all facilities including ventilators are available.
- Detailed record of the procedure done, anaesthesia, findings during surgery are written in the operation notes by the resident, approved by consultant and attached to the case file.
- In the post - operative period the patient is monitored daily by the resident alone & with consultant. Clear notes is made on the daily condition, progress, treatment, drugs used, investigation done. Prior (1 - 2 days) to discharge, a detailed summary is prepared by the resident & approved by the consultant which includes advice regarding diet, exercise, drugs, abstinence and follow up. The patient is discharged after suture removal on seventh day.

➢ GENERAL PROTOCOLS

➢ History Taking In Obstetrics & Gynecology

1. Booked (at least 3 visits in OPD) / Unbooked (in cases of pregnancy) .
2. LMP (first day of last Menstrual period).
   EDD (if given).
3. Past Menstrual History – days of bleeding, frequency of bleeding days (gap from 1st day).
4. OBSTETRICAL HISTORY – G. P. L. A.D
   Gravida – No. of times patient has conceived.
   Parity – No. of times patient has given birth to baby after 5 months of gestation.
   Living – No. of living children.
   Abortions – No. of Abortion, Dead
5. Last child birth (duration).
6. Last Abortion (duration.)
7. P/H – Particular reference to –
   - Jaundice
   - Blood Transfusion
   - Asthma
   - Tuberculosis
   - Epilepsy
   - HT
   - DM
8. F/H – DM, HT, Twine, cardice disease, allergies.
9. D/H – Allergies & on any medication presently / past.
10. History of Immunisation – Inj TT – one, two, three.
11. Physical Examination
    - GC
    - P
    - BP
    - Temp
    - Pallor
    - Oedema
    - Icterus
    - CVS
    - Resp
    - PA
    - PV

12. Provisional Diagnosis.
13. Investigations if any done previously to be noted in file along with date of report.

➢ Protocol For Routine Cases In Obstetric & Gynecology

1. Making of consultation card and taking fee at reception.
2. Directing to Consultant Room.
3. History taking, examination, advice & treatment by gynaecologist.
4. In case of advised investigation reporting back to reception, payment to be made there & receiving directions for Room No. according to investigations.
5. Showing of reports to consultant and change / continuation of treatment. Enter the same & any previous reports in the file.
6. If admission advised & agreed to by patient, information to reception for sending of wheel chair / Trolley to OPD chamber, Making of file at reception & transfer of patient to emergency / GW / ICU / Semiprivate / Pvt Room. Informing Doctor on Duty to execute the instruction on file / card.
7. Patient to be received by Dr & Staff Nurse on duty at respective place.
8. In case of any query, consult the gynaecologist concerned.

➢ Protocol For MTP Cases / Minor Cases On Day Care Basis

1. After history & examination by gynaecologist, take consent, inform Labour room / OT staff, inform anaesthetist if so desired. If needed file be made at reception & filled by gynaecologist.
2. ICU / OT staff to prepare the parts, gives Inj TT. Shift patient to OT / Labour room for procedure.
3. After completion of procedure, shift to emergency / ICU as per availability of beds.
4. Medicines will be written by gynaecologist in MTP cases and in cases where admission is made. Discharge to be made by Dr. on Duty in Emergency / Ward. Patient may be discharged after effect of anaesthesia wears off or as advised by consultant.

- **MTP ACT, 1971**
- The Medical Termination of Pregnancy Act, 1971
- **(Act No. 34 of 1971)**
  (10th August 1971)
- An Act to provide for the termination of certain pregnancies by registered Medical Practitioners and for matters connected therewith or incidental thereto.
- Be it enacted by Parliament in the Twenty-second Year of the Republic of India as follows:-
- 1. Short title, extent and commencement
- (1) This Act may be called the Medical Termination of Pregnancy Act, 1971.
- (2) It extends to the whole of India except the State of Jammu and Kashmir.
- (3) It shall come into force on such date as the Central Government may, by notification in the Official Gazette, appoint.
- 2. Definitions-In this Act, unless the context otherwise requires
- (a) Guardian means a person having the care of the person of a minor or a lunatic;
- (b) Lunatic has the meaning assigned to it in section 3 of the Indian Lunatic Act, 1912 (4 of 1912);
- (c) Minor means a person who, under the provisions of the Indian Majority Act, 1875 (9 of 1875), is to be deemed not to have attained his majority;
- (d) Registered medical practitioner means a medical practitioner who possesses any recognized medical qualification as defined in clause (h) of section 2 of the Indian
- Medical Council Act, 1956, (102 of 1956), whose name has been entered in a State Medical Register and who has such experience or training in gynecology and obstetrics as may be prescribed by rules made under this Act.
- 3. When pregnancies may be terminated by registered medical practitioners
- (1) Notwithstanding anything contained in the Indian Penal Code (45 of 1860), a registered medical practitioner shall not be guilty of any offence under that Code or under any other law for the time being in force, if any pregnancy is terminated by him in accordance with the provisions of this Act.

- (2) Subject to the provisions of sub-section (4), a pregnancy may be terminated by a registered medical practitioner, -

- (a) Where the length of the pregnancy does not exceed twelve weeks if such medical practitioner is, or

- (b) Where the length of the pregnancy exceeds twelve weeks but does not exceed twenty weeks, if not less than two registered medical practitioner are, of opinion, formed in good faith, that -

- (i) The continuance of the pregnancy would involve a risk to the life of the pregnant woman or of grave injury to her physical or mental health; or

- (ii) There is a substantial risk that if the child were born, it would suffer from such physical or mental abnormalities to be seriously handicapped.

- Explanation 1- Where any pregnancy is alleged by the pregnant woman to have been caused by rape, the anguish caused by such pregnancy shall be presumed to constitute a grave injury to the mental health of the pregnant woman.

- Explanation 2- Where any pregnancy occurs as a result of failure of any device or method used by any married woman or her husband for the purpose of limiting the number of children, the anguish caused by such unwanted pregnancy may be resumed to constitute a grave injury to the mental health of the pregnant woman.

- (3) In determining whether the continuance of a pregnancy would involve such risk of injury to the health as is mentioned in sub-section (2)account may be taken of the pregnant women's actual or reasonable foreseeable environment.

- (4) (a) No pregnancy of a woman, who has not attained the age of eighteen years, or, who, having attained the age of eighteen years, is a lunatic, shall be terminated except with the consent in writing of her guardian.
  (b) Save as otherwise provided in clause (a), No pregnancy shall be terminated except with the consent of the pregnant woman.
- 4. Place where pregnancy may be terminated -
- No termination of pregnancy shall be made in accordance with this Act at any place other than -
- (a) A hospital established or maintained by Government, or
- (b) A place for the time being approved for the purpose of this Act by Government.
- 5. Sections 3 and 4 when not to apply -
- (1)The provisions of section 4, and so much of the provisions of sub-section(2)of section 3 as relate to the length of the pregnancy and the opinion of not less than two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of opinion, formed in good faith, that determination of such pregnancy is immediately necessary to save the life of the pregnant woman.
- (2)Notwithstanding anything contained in the Indian Penal Code (45 of 1860), the termination of a pregnancy by a person who is not a registered medical practitioners hall be an offence punishable under that Code, and that Code shall, to this extent, stand modified.
- Explanation-For the purposes of this section, so much of the provisions of clause (d) of section(2)as relate to the possession, by a registered medical practitioner, of experience or training in gynecology and obstetrics shall not apply.
- 6. Power to make rules -
- (1) The Central Government may, by notification in the Official Gazette, make rules to carry out the provisions of this Act.
- (2) In particular, and without prejudice to the generality of the foregoing power, such rules may provide for all or any of the following matters, namely
- (a) The experience or training, or both, which is registered medical practitioner shall have if he intends to terminate any pregnancy under this Act and

- (b) Such other matters as are required to be or may be, provided by rules made under this Act.
- (3) Every rule made by the Central Government under this Act shall be laid, as soon as may be after it is made, before each House of Parliament while it is in session for a total period of thirty days which may be comprised in one session or in two successive sessions, and if, before the expiry of the session in which it is so laidor the session immediately following, both Houses agree in making any modification in the rule or both Houses agree that the rule should not be made, the rules hall thereafter have effect only in such modified form or be of no effect, as the case may be; so, however, that any such modification or annulment shall be without prejudice to the validity of anything previously done under that rule.
- 7. Power to make regulations -
- (1) The State Government may, by regulations-
- (a) Require any such opinion as is referred to in sub-section (2) of section 3 to be certified by a registered medical practitioner or practitioners concerned, in such form and at such time as may be specified in such regulations, and the preservation or disposal of such certificates ;
- (b) Require any registered medical practitioner, who terminates a pregnancy, to give intimation of such termination and such other information relating to the termination as may be specified in such regulations;
- (c) Prohibit the disclosure, except to such purposes as may be specified in such regulations, of intimations given or information furnished in pursuance of such regulations.
- (2) The intimation given and the information furnished in pursuance of regulations made by virtue of clause (b) of sub-section (1) shall be given or furnished, as the case may be, to the Chief Medical Officer of the State.
- (3) Any person who willfully contravenes or willfully fails to comply with the requirements of any regulation made under sub-section (1) shall be liable to be punished with fine, which may extend to one thousand rupees.
- 8. Protection of action taken in good faith -
- No suit or legal proceedings shall lie against any registered medical practitioner for any damage caused or likely to be caused by anything, which is in good faith done or intended to be done under this Act.

➢ Protocol for Indoor Gynaec Patients

1. History taking, examination, investigations (if opted) as OPD cases.
2. File to be made at reception.
3. Shift patient to opted ward / room.
4. Taking samples for blood & urine, getting ECG & X-ray done. Placement of cannula by S/N.
5. Follow up of reports by Resident Dr. & if all are normal, take appointment with anaesthetist as per time specified. Blood to be arranged if Hb is low.
6. Pre op orders by gynaecologist.
7. Physical Fitness & Pre-Anaesthetic check up.
8. Informing OT staff about timing of surgery.
9. Pre opd orders to be executed by staff nurse.
10. On day of surgery shift patient to ICU 15min prior to appointment time.
11. Shift patient to ICU / Ward as per instructions after surgery.
12. Foot end of bed to be raised for 6hrs in cases done under spinal anaesthesia on day 1 of surgery.
13. Vitals charting ½ hrly * 2 hrly then 2 hrly * 12 hrs
14. On first day of surgery patient may be permitted to move on bed i.e. change position as per choice.
15. I/O charting * 2hrly. To inform consultant if urine output less than 100ml in 2hrs.
16. Shift out of ICU as & when instructed after getting bed/room ready, after giving over on phone / personally.
17. On day 2 of surgery patient should be sponged, propped, breathing exercises to be demonstrated, patient may be made to sit on, anticlockwise movements at ankle to be demonstrated.
18. When allowed fluids orally, see that fluid is clear of any residue and patient is not fed in lying down position.
19. On day 3, (post operative) sponge to be given & patient to be permitted out of bed within the room with support initially & then without support.
20. After patient passes motion, omit IV fluids and start semisolid diet.
21. Oral medication may be started after patient passes motion.
22. On day of planned discharge or day prior to it, discharge summary be prepared and explained to the patient at time of discharge. Proper advice to be given regarding place, time, day & date of follow up.
23. In case of delivered / Caesarean patients, direct the attendants for follow up advice regarding baby & its vaccination by paediatrician.
24. Handing over of discharge summary to patient after clearing of the bill.

➢ Interaction with Other Departments

a) In case of gynaecological malignancies advice of oncologists (Medical, surgical, Radiation) may be sought in the care of the patient.
b) In cases of heart disease a patient contemplating gynaecological surgery, requires opinion and advice of the cardiologist.
c) Endocrinologist opinion is sought in the case the patient has an endocrine problem e.g. hypothyroidism, diabetes.
d) Physician's advice is sought for control of diabetes prior to surgery.

➢ Referrals

Requests for gynaecological opinion and advice are made by consultants from other departments and are seen by the consultants and residents. After evaluation, examination and investigations, necessary treatment and follow up is suggested. Gynaecological advice is sought by

a) Ortho surgeons considering oestrogen replacement therapy for patients with severe osteoporosis & fractures.
b) In patient admitted in other departments with gynaecological complaints.

➢ CLINICAL PROTOCOLS

➢ Severe PIH

Investigation	**Management**	**Instructions To Staff Nurse**
Routine Investigations	Anti-Hypertensive's	BP 2hrly + SOS
+ BT, CT, PT, Platelets.	Antibiotics	Watch for severe headache, epigastric pain, blurring of vision
Sr Electrolytes, LFT	Inj Betamethasone. according to period of gestation & severity of PIH (less than 37 weeks).	Convulsions FHR Monitoring
Sr Uric Acid	MGSO4 in impending eclampsia.	I/O chart
Sr Creatinine	Induction of labour according to gestation &	No Methergine at the time of delivery

	severity of PIH.	
Urine Albumin		
Fundus Ex		
If required SGOT, SGPT		

- Eclampsia

Investigation	**Management**	**Instructions To Staff Nurse**
Routine + All Investigations of PIH	Antibiotics	Inhalation SOS
	MGSO4 4gm IV stat diluted with NS 20cc over a period of 15min, Followed by 5mg on either Buttock, followed by 5mg on alternate buttock every 4 hourly upto 24 hrs.	Airway Respiratory Rate (RR) & Knee Jerk 1hrly
	Antihypertensives like Depin SOS.	I/O charting 2hrly.
		Stop $MgSO_4$ if RR is less than 12/min.
	Vitals every 15min.	Knee jerk – if absent inform Doctor & stop MGSO4 drip.
	Phenytoin 600mg in 200cc of NS over ½hr then 100mg 8hrly or 300mg HS.	Urine output if less than 100ml/hr stop MGSO4 drip & Inform Dr. on Duty
		Urine Alb charting BD.
		Care of mouth, Bowel & Back.

- Ante partum Hemorrhage

Bleeding from or into the genital tract before 28 weeks of pregnancy, but prior to the birth of the baby.

NO PV TO BE DONE

Investigation	**Management**	**Instructions To Staff Nurse**
Routine Investigation	Antibiotics	Vitals ½ hrly.
+ BT, CT, PT, Platelet.	Arrange Blood according to Hb.	Watch for Blood PV.
U.S.G Obstetric urgent for retroplacental clots or placental localization and assessment of gestation age.	Termination of pregnancy according to condition of Patient & U.S.G report.	O2 should be ready FHR monitoring.
	Strict Bed Rest.	Baby's Hb to be sent if paediatrician so feels the need.

- I/V Fluid Infusion

1. The gynaecology is advised to write clear & legible orders.
2. The rate at which I.V infusion to be given should be clearly mentioned in drop rate/ ml or ml/ hr.
3. The sister will mark bottle no as 1.2.3 on the bottle label. Also the marking should be done in the file / treatment chart.
4. Watch for over-hydration i.e. if there is swelling on the face, eyes or body, further I/V infusion should be stopped after consulting the Doctor.
5. In the children on measured doses of I/V fluid, regular check-up is mandatory to ascertain that the fluid infusion is as per orders only i.e. it should neither be less nor more than the requirement.

Changing I/V Fluids

1. The sister has to use one I/V set for I/V fluids & other separate I/V set for drugs (e.g. I/V Cipro, Metrogyl, Mannitol etc.)
2. In every round, the sister should check the remaining I/V fluid in the bottle. If there is only 20-30 ml of fluid is remaining, the sister should give it fast and only after disconnecting or changing the I/V, she should leave the bed. In between, the rate of infusion should be checked.

- Putting Cannula

Attendants should be kept outside when you are placing cannula.

1. At first all the equipments you need for placing cannula (18, 20, 22, 24 cannula, tourniquet spirit swab and leucoplaster (cut in between) should be kept ready.
2. The part where cannula has to put should be cleaned, shaved and then cleaned properly by spirit swab.
3. After visualizing the vein properly, at first pierce skin nearby vein and then go into vein. There is no need to withdraw stylet to confirm that the cannula is in vein. If cannula is in vein then blood will come in back compartment of cannula.
4. After seeing the blood in back compartment of cannula, push the cannula by finger in vein.
5. After doing these cut at first, dry the area, then apply leucoplast to fix the cannula.
6. Mark on the leucoplaster date and time of insertion and number of cannula like I, II etc.
7. If you have to withdraw any sample then attach the syringe to the cannula after removing stylet (vein should be compressed by thumb before removing stylet) and then withdraw sample.
8. No sample should be taken directly into tube or vial from cannula.

9. Then again compress the vein and attach I.V fluid to the cannula. If I.V fluid is not to be connected then Heparinise the cannula.
10. In Morning round, each cannula should be checked by sisters and Resident Doctors for any signs of thrombophlebitis or leak.
11. As soon as the signs of Thrombophlebitis develop, the cannula should be changed.

- Oxygen Supply

Before connecting O_2, the main supply must be checked. Check if there is enough water in O_2 calibrator and if the calibrator is working well without any air leak.

O_2 can be provided with

1. Disposable nasal prongs - Ideal for pts of MI, Put anesthesia where the respiratory rate is more or less normal.
2. O_2 mask – Plain simple mask used mostly for patients with more of mouth breathing as in acute exab. Of COPD, Asthma, LVF.
3. Venturi mask – A variant of O_2 mask where O_2 flow can be calibrated depending on need of patient useful in weaning patients from ventilators, COPD with exacerbation.
   Depending on the % flow of the mask, O_2 flow should be adjusted.

   24% (blue) 2-4 l/min

28% (white)	4-6 l/min
32% (orange)	6-8 l/min
35% (yellow)	8-10 l/min
40% (red)	10-12 l/min
60% (green)	12-15 l/min

➢ Catheterization Of Urinary Bladder

1. Upon deciding for catheterization, the patient or their attendants should be informed.
2. Strict asepsis should be maintained. The resident should wash his hands and dry them before putting gloves.
3. The part should be cleaned with savlon and then Betadine. Once Betadine dries up, it should be drapped and urethral opening identified.
4. Usually size 14/16 Foley's plastic catheters are used.
5. Adequate Xylocaine Jelly lubrication should be introduced in the urethra esp. in males prior to catheterisation.
6. Catheter should be inserted till the bifurcation (e.s.p. in males). The balloon should then be inflated with 15-25cc of distilled water.
7. The prepuce should be retracted back in Males.
8. In case in-patients with BHP or stricture, a narrow gouge catheter may be used. Never force the catheter as it may cause false passages.
9. Catheters should be flushed with diluted betadine solution retrograde once every 3-4 days to maintain bladder asepsis.
10. Catheters should be changed every 7-10 days if indwelling for long periods.
11. The whole system should be closed with no leaking of urine from anywhere to prevent retrograde infection of bladder.
12. Urine cultures may be sent once a week if a patient on catheter develops fever and appropriate antibiotics introduced

➢ Ultrasound

1. For upper abdomen scanning, patient should preferably be empty stomach.
2. For scanning uterus & adnexa (pelvis) full bladder is mandatory.
3. In case the patient is cathetorised, clamp the cathetor for 2-3 hrs before sending him for U.S examination.
4. For scanning Kidneys, Uterus, Bladder, Prostate, full bladder is necessary.
5. In case the patient comes to casualty in severe pain, give him analgesic injection first & let pain settle down a bit before sending him to U.S room.
6. If the patient is in shock or very serious, stabilize him first.

7. In case the doctor is called for performing urgent U.S ex, resident doctor should see to if the patient has full bladder & if not before sending him to U.S room, give him injection Laxis I/V
8. For indoor patients, to reduce waiting time outside U.S room, make a phone call before sending the patient.
9. Whosoever sends patient to the U.S room, it's his duty to see to it that the report is collected before 1 p.m from U.S room.
10. In case any Obstetrics patient comes from outside, before
11. taking charges from her, reception people should see that she has prescription of qualified doctor with indication for scanning written on it.
12. Above all no Sex-determination of fetus is done here

➢ LABOR ROOM

➢ PURPOSE

The purpose is to improve the health of women and their babies by promoting the highest possible standards of care at GKHPL.

➢ SCOPE

The Department of Obstetrics and Gynecology offers comprehensive services for the reproductive health and gynecological needs of women.

➢ OVERALL RESPONSIBILITY

Gynecologist & Obstetrician

➢ PROCESS PARTICIPANTS

- Nursing staff
- Anesthetist
- Front office staff
- OT Technicians
- Pediatrician
- RMO/EMO
- House-keeping staff
- Medical record department.

➢ POLICIES

Obstetric & Gynaec facility is provided both as:

1. OPD &
2. IPD

1. OPD: - The OPD facility of GKHPL includes:

- Obstenic & Gynecology consultation.
- High risk pregnancy clinic.
- Fetal medicine clinic.
- Infertility clinic
- Recurrent miscarriage clinic.
- Menopausal Clinic.
- Gynecological Cancer screening clinic.
- Gynae work station with flexible office hysteroscopy& colonoscopy.
- Ultra Sonography
- Urogynaecology clinic

2. IPD:

Management Protocol In Obstetrical Emergencies

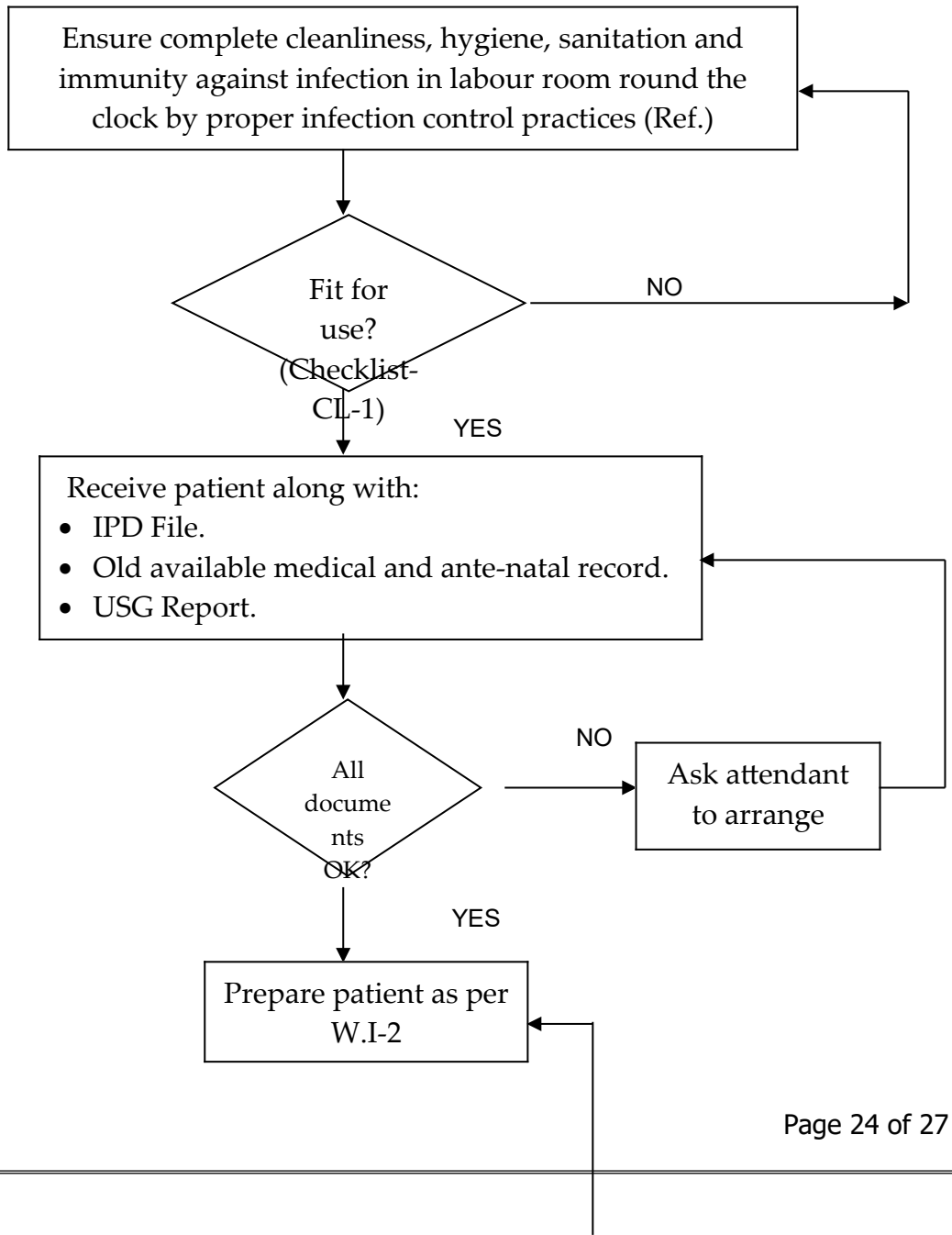
1. Patient should be transported on a trolley (never on wheel chair).
2. Watch for vitals, uterine contractions (presence/absence) and fetal heart rate presence or absence (in pregnancy beyond 16 weeks) at the time of admission.
3. Inform consultant after detailed history and first hand examination (format provided).
4. Never perform Per Vaginal Examination in case of Pregnancy with bleeding per vaginum.
5. In routine labour cases PV not be repeated unless indicated or advised in less than 6 hrs.
6. While cleaning & shaving perineum move the swab from above downwards in a single stroke & discard the swab (from pubes to anus) perennial area to be shaved last of all.
7. Do not keep Obstetrical & Gynae patients Nil orally for U.S.G unless specified.
8. Full Bladder is a prerequisite in early pregnancy (upto 18 weeks) and gynae U.S.G.
9. No requirement for medicines in Pregnancy unless specified by consultant like :-
    - Diclofenac Sodium/Potassium
    - Fortwin
    - Phenargan.
    - Steroids
    - Botropase/Revici
    - Ciproflaxacin/Norfloxacin.

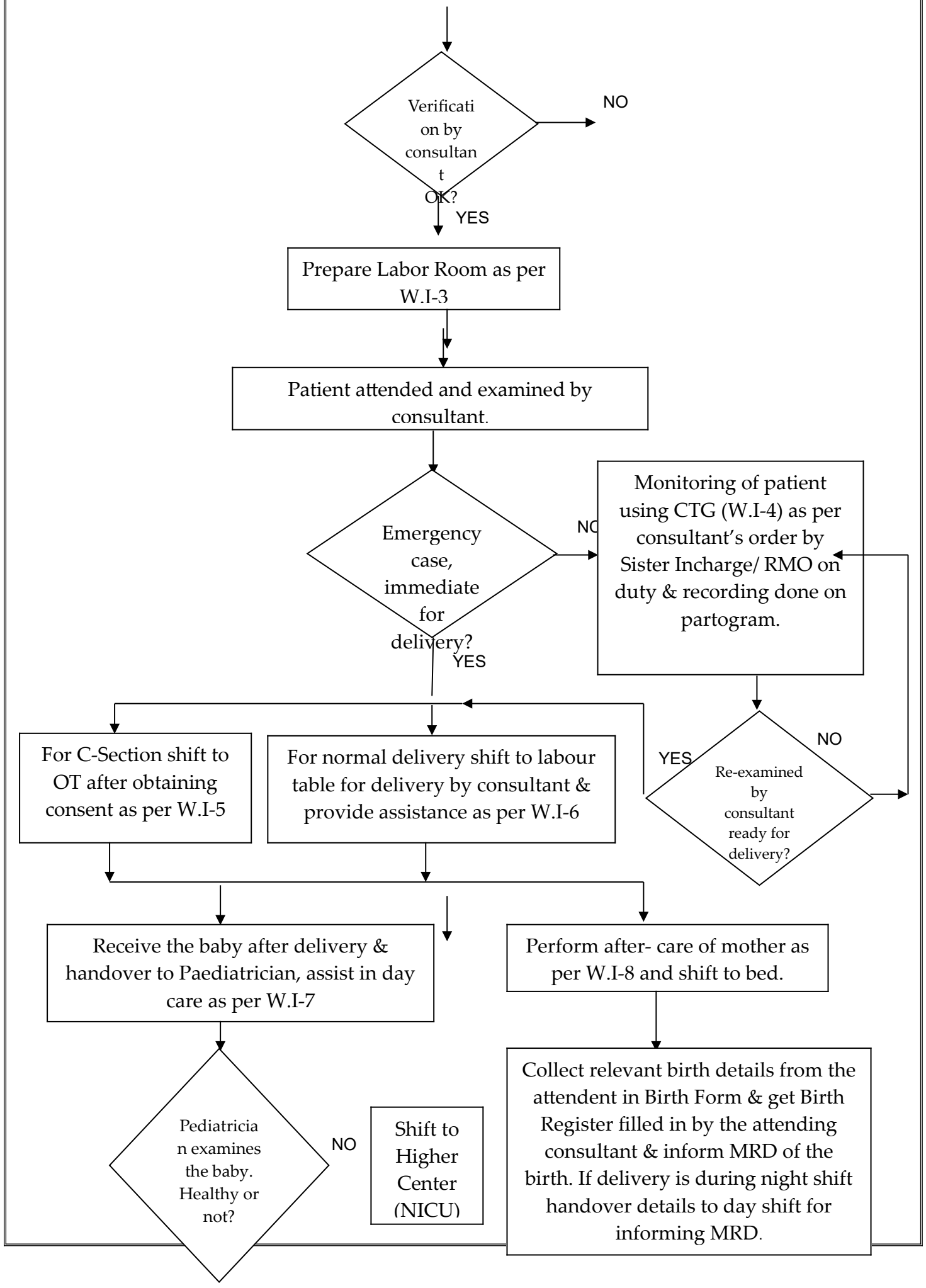
- Normal Labour

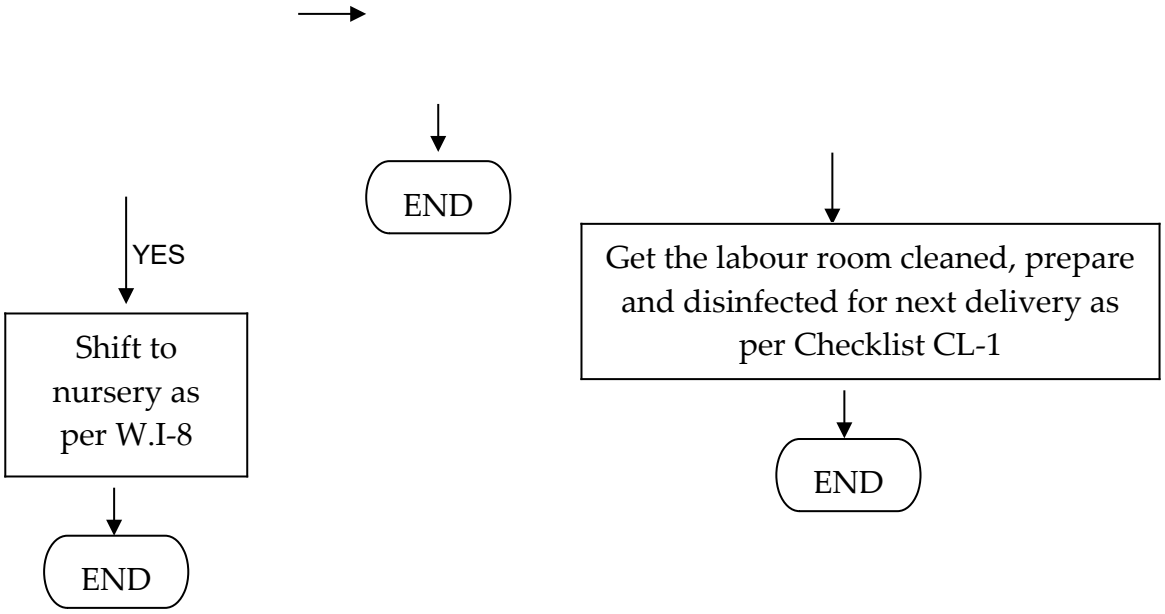
Investigations (To Check If Done Earlier)	Management	Instructions To Staff Nurse
CBC	Take Consent (Even For Labour)	Change Clothes.
Blood Group	Practoclysis Enema	Remove Ornaments & Hand Over To Relative After Taking Signature Of Receipt.
HIV, HCV, VDRL	Prepare Parts	Clean & Cut Nails And Clean Lipstick.
Hbs Ag	Xylocaine Sensitivity	Clear Fluids Orally (If Not Advised Nbm).
RBS, BT, CT	Inj Gdw 5% + Syntocinon 1-2 Units.	Encourage Patient To Evacuate Bladder From Time To Time.
	Watch For FHR-1/2 Hrly Watch Vitals – 2 Hrly /Sos	If Advised Lscs Change Syntocinon Drip To Gdw 5%. Give Rantac, Perinorm.
	Antibiotics After Arm Or If Patient Admitted With H/O Leaking Pv Or Handling By Dai.	Do Not Permit To go to Toilet Rather Give A Bedpan.
	Watch For Uterine Contractions - > Frequency Of Contraction (Hardness In Uterine Region).	Keep Delivery Set & Neonatal Resuscitation Unit Ready In Labour Room.
	Inform The Obs Consultant SOS.	Shift Patient To Labour Room After Preliminary Rx Along With Doppler.
	Inform The Paediatrician Immediately & At Time Of Delivery.	Chart Vitals, Uterine & FHR Contraction.
	Give & Take Over Of FHR (Presence/ Absence & Rate)	

	Always.	
	Note Colour Of Liquor In Leaking Or After Arm.	

➢ Process Flow Chart




Verification by consultant OK?
NO
YES
Prepare Labor Room as per W.I-3
Patient attended and examined by consultant.
Emergency case, immediate for delivery?
NO
YES
Monitoring of patient using CTG (W.I-4) as per consultant's order by Sister Incharge/ RMO on duty & recording done on partogram.
Re-examined by consultant ready for delivery?
YES
NO
For C-Section shift to OT after obtaining consent as per W.I-5
For normal delivery shift to labour table for delivery by consultant & provide assistance as per W.I-6
Receive the baby after delivery & handover to Paediatrician, assist in day care as per W.I-7
Perform after- care of mother as per W.I-8 and shift to bed.
Pediatrician examines the baby. Healthy or not?
NO
Shift to Higher Center (NICU)
Collect relevant birth details from the attendent in Birth Form & get Birth Register filled in by the attending consultant & inform MRD of the birth. If delivery is during night shift handover details to day shift for informing MRD.



- Preterm Labour

With or without leaking PV

Investgation	Management	Instructions To Staff Nurse
Routine investigation (as in Normal Labour)	Duvadilan drip 2 amp +500cc of GDW 5%. Yutopar drip (Ritodrine HCL) 2 amp + GDW at 5-10 drops/min. Time Rate Dose Infuse 10min 5drops/min 50mg Next 10min 10drops/min 100mg Next 10min 15drops/min 150mg Continue at this rate till uterine contraction cease (stop) or Maternal HR>140/min. When advised to stop Yutopar drip give 1 tab (10mg) 30 min before stopping the drip. (Max oral dose is 120mg in divided doses).	Temp charting 6 hrly.
TLC, DLC	Antibiotics	BP, Pulse 2 hrly
High Vaginal Swab for culture & sensitivity prior to starting antibiotic & prior to PV	Strict monitoring of pulse & BP.	If leaking watch for color of liquor on pad.
Urine R Ex	Inj Betamethasone 12mg 1.ml	Rest is like Normal

	repeat after 24 hr	Labour.
U.S.G Obstetrics for exact gestation age.	If leaking PV + give sterile pad and also raise foot end of bed.	
	Strict bed rest.	