A.S.S AYURVED MAHAVIDYALAYA ,NASHIK

STREEROG PRASUTITANTRA DEPARTMENT

SOPS FOR PRACTICES

1) YONI PRAKSHALANA

DEFINITION

This is the special procedure with which asepsis is produced . This can be correlated with irrigation of vagina or douche

STANDARD OPERATING PROCEDURE MATERIAL REQUIREMENT

- Sterile gloves Gauge piece Cotton
- Kwatha Douche Can Rubber tube
- Vaginal nozzle
- Sponge holding forcep

PURVA KARMA

- Take consent for the procedure and evaluate patient safety for before procedure as per pre procedure checklist
- Patient is advised to empty her bladder
- Prepare kwatha

PRADHANA KARMA

- Position . Dorsal position with thigh flexed .
- Vaginal nozzle will be inserted in vagina without lubrication Then slowly wash with 500 ml medicated kwatha in clockwise and anticlockwise wise direction

PASHCHATA KARMA

- Patient is advised to cough for expulsion of the remaining kwatha from vagina . • Clean the vulva and vagina with care piece
- Post procedure evaluation should be written in patient's file

2) YONI PICHU

DEFINITION

Dipping of a gauze piece in Taila or Ghrita and kept in vagina is called Yoni Pichu .

STANDARD OPERATING PROCEDURE MATERIAL REQUIREMENT

Sterile gloves Gauge piece Medicated oil / Ghrita Bowl

PURVA KARMA • Take consent for the procedure and evaluate patient safety for before procedure as per pre procedure checklist Patient is advised to empty her bladder .

• Slightly warm Oil / Ghrita

PRADHANA KARMA

• Position - Dorsal position with thigh flexed .

• Sterile gauze piece will be dipped in medicated oil / Ghrita and then enter it in the vagina

PASHCHATA KARMA

• The gauze piece should be removed after 2-3 hours or when patient feels urine sensation Post procedure evaluation should be written in patient's file

3) AGNI KARMA

STANDARD OPERATING PROCEDURE MATERIAL REQUIREMENT

- Sims speculum
- Anterior vaginal wall retractor
- Sponge holding forceps
- Vullselum forceps
- Sterile gloves
- Candle Matches
- JatyadiTaila
- AgnikarmaShalaka
- Gauge Piece
- Cotton

PURVA KARMA

• Take consent for the procedure and evaluate patient safety for before procedure as per pre procedure checklist

- Patient is advised to empty her bladder .
- Yoni Prakshala with Panchavalkalakwatha

PRADHANA KARMA

- Position - lithotomy position
- Painting with antiseptic solution at vulva and vagina .
- Visualize cervix by using Sims speculum and anterior vaginal wall retractor
- Catch the anterior lip of cervix by vullselum forcep .
- Clean the site of cervical erosion with caute piece AgnikarmaShalaka will be heated by candle , and then Bindu type of Agnikarma will be applied over the affected part
- The sign of SamyakaDagdha is seen like PakwaambuPhalavata , the flesh is burnt (at affected part) . assume a bluish brown colour is marked .

PASHCHATA KARMA

- Jatyadi Taila will be applied over the treated part .
- Remove all instruments
- Bed rest for 2 hours
- Post procedure evaluation should be written in patient's file

4) UTTARA BASTI

Definition

Uttara Basti is a procedure in which medicine in form of Tata / Ghrita las made to pass through Yoni in to Garbhasaya and through mutra Marga to Mutrasata in female

STANDARD OPERATING PROCEDURE MATERIAL REQUIREMENT

- Sims speculum
- Anterior vaginal wall retractor
- Sponge holding forcep
- Vullselumforcep
- Uterine sound
- Uttara Basticanula
- Syringe Bowl
- Sterile gloves
- Gauze piece
- Cotton
- Oil / Ghrita

PURVA KARMA

- Take consent for the procedure and evaluate patient safety for before procedures per pre procedure checklist

- Whole body Abhyanga with medicated old (bala taila / Narayana Tail for 20 minutes SarvangaBashpaSweda by Nirgundi Putra Kwatha for 10 minutes Yoni Prakshala with Panchavalkalakwatha
- Prepare operation theatre trolley

PRADHANA KARMA

- Position Lithotomy position
- Painting with antiseptic solution at vulva and vagina
- Visualize cervix by using Sims speculum and anterior vaginal wall retractor
- Catch the anterior lip of cervix by vulselumforcep
- Determine length and position of uterus by uterine sound
- Uttara Basticanula introduced in the direction of uterine cavity , then 1/5 ml medicated Tala / Ghrita is injected with syringe from other side of canula Remove all instruments

PASHCHATA KARMA

- Patient is given head low position for 15 minutes
- Post procedure evaluation should be written in patient's file.

SOP FOR: Care of Obstetrical Patients

1. Purpose:

To provide comprehensive care in the specialty of Gynecology and Obstetrics including management care of high risk pregnancy

2. Scope:

Extends to all staff and patients under the purview of department of obstetrics and Gynecology

3. Responsibility:

Consultant doctor, Medical Officers, Staff nurses

4. Policy:

i. Experienced Gynecologist is available in the hospital for OPD consultation and also available on call 24 hours as required in case of emergency.
ii. Medical Officers are present 24 hours for initial assessment of any patient.
iii. Nurses: suitably qualified nurses, experienced provide care in the Labor Room.
iv. Pediatric consultants are available 24hours on call as well as for OPD twice a day.

5. OPD Services:

The OB&G outpatient clinics functions six days a week from 10:00 am to 12:00 noon. The services aim at providing diagnostic, curative, preventive, and rehabilitative services on an ambulatory basis.

6. Emergency Services:

The Emergency department of the hospital functions round the clock with qualified gynecologist available 24 hrs.

7. Inpatient Services:

The inpatient services are meant for patients requiring regular monitoring in the inpatient care facility of the hospital.

Patients in labor are admitted for the delivery in the ward.

8. Diagnostic services:

i. 24 hr on call labor services for routine and urgent tests like clotting profile.
ii. Radiologists to perform USG in case of emergency.

9. Provision of care:

a) **Antenatal:**

i. 24 hrs emergency
ii. Antenatal well being programmer to prepare patients for delivery.
iii. Consultation with dietician for diet modifications if required.

b) Intranatal:

i. Well Equipped Labor Room Facility
ii. Trained nursing support for high risk cases
iii. 24 hr OT availability
iv. Facility for instrument vaginal delivery

9. Inpatient Admission:

The patient requiring in-patient care would be suggested so in writing by the treating consultant. No patient admitted in IPD facilities without written request of treating consultant, on duty the staff nurse receives the patient.

9.1. OPD hours:

During OPD working hours of the hospital, the patient is seen in the OPD of the consultant doctor who after assessing the patient determines the need for inpatient admission. In case the patient is to be admitted, the same is indicated in writing, admission note is handed over to patient/relative. (Refer to admission policy).

If the patient is directly taken to the emergency department, the on duty doctor and nursing staff assess the patient and informs Gynaec Consultant immediately. The patient is seen by consultant immediately (if required) and treatment is initiated. In case the patient needs inpatient admission the same is indicated and the admission procedure is initiated as per the admission policy of the hospital.

9.2. Non OPD hours:

Patient is directly taken to the emergency department, the on duty doctor assesses and informs the consultant and the initial treatment is initiated. Consultant will reach the hospital as early as possible.

On arrival the Consultant examines the patient and initiates the treatment. In case the patient is to be admitted, the CMO indicates the same in writing. The patient is admitted as per the hospital policy and treatment is initiated.

9.3. Referral of patient to other specialty:

If the primary treating consultant of the patient feels the need to refer the patient to consultants of some other specialty, a referral slip is filled by the primary treating consultant of the patient with details relating to the patients complain, diagnosis and treatment initiated.

The referral slip is attached with the patient case record for the perusal of the referred consultant.

9.4. Transfer of patient to other hospital:

If the patient cannot be treated in the hospital due to personal and financial reasons she is shifted to outside center as per availability.

9.5. Management of High Risk Pregnancy:

A high risk pregnancy is one in which some condition puts the mother, the developing fetus, or both at higher than normal risk for complications during or after the pregnancy and birth.

a) Diagnosis:

A woman with a high-risk pregnancy will need closer monitoring than the average pregnant woman. Such monitoring may include more frequent visits with the primary caregiver, tests to monitor the medical problem, blood tests to check the levels of medication, amniocentesis, serial ultrasound examination, and fetal monitoring. These tests are designed to track the original condition, survey for complications, verify that the fetus is growing adequately, and make decisions regarding whether labour may need to be induced to allow for early delivery of the fetus.

Nutritional Assessment of the patient forms an integral part of the diagnosis process. This is done to ensure the nutritional status of the mother and fetus .The findings of the patient's nutritional and the clinician's recommendations on the same are documented in the patient care record.

b) **Treatment:**

Treatment varies widely with the type of disease, the effect that pregnancy has on the disease, and the effect that the disease has on pregnancy. Additional tests may help determine the need for changes in medication or additional treatment.

The Obstetric department of IASIS hospital is competent to handle high risk pregnancies. For this there is qualified and trained Consultant & well trained nursing staff. Facilities for undertaking such pregnancies are available in the hospital. In case of associated complication the hospital has fully equipped Intensive Care Units functional on a 24hrs basis. The High Risk pregnancies include the following but are not exhaustive:

i. Pre Eclampsia & Eclampsia
ii. Intra Uterine Growth retardation
iii. Post Partum haemorrhage
iv. Non-reassuring Fetal heart Tracing
v. Premature rupture of membrane
vi. Post Dated Pregnancy
vii. Prolonged Labor
viii. Cord Prolapse
ix. Placenta Previa
x. Diabetes Complicating Pregnancy
xi. Obstructed Labour

10.General Guidelines for Gynaec Procedure:

10.1. P.V Examination:

10.1.1. Purpose:

i. To make a positive diagnosis of true labor.
ii. To make a positive identification of presentation.
iii. To determine whether the head is engaged in case of doubt.
iv. To ascertain whether the fore water have rupture or to rupture them artificially.

v. To exclude cord prolapsed after the rupture of the fore water especially if there is an ill fitting present part.
vi. To assess progress or delay in labor.
vii. To confirm full dilatation of cervix.
viii. In multiple pregnancies to confirm the lie & presentation of the second twin & in order to puncture the second amniotic sac.

10.1.2. Responsibility:

Doctor/Staff Nurse

10.1.3. Equipments/ requirement:

i. P.V. pack containing Sim's speculum
ii. Sterile cotton swabs
iii. Sterile disposable gloves
iv. Lubricating jelly (water soluble jelly)
v. Under sheet

10.1.4. Procedure:

i. The doctor/ nurse should first explain the procedure carefully to the client.
ii. The client should be given the opportunity to empty bladder.
iii. Provide privacy
iv. The client lies on dorsal position with her knees drawn up. (The thigh should be separated & the knees bend).
v. A vaginal examination is an aseptic procedure, so wash hands & put gloves.
vi. The vulva is cleaned using the non dominant hand.
vii. The two fingers of dominant hand are lubricated with Lubricating jelly & gently inserted downwards & backwards into the vagina, while the labia are held apart by thumb & finger of the other hand.
viii. The finger are directed along the anterior vaginal wall & should not be withdrawn until the required the information has been obtained.
ix. While P.V. the thumb must not be brought into contact with the anus where it may be contaminated, or the clitoris where it may cause great discomfort.
x. After the vaginal examination clean the part with sterile cotton swab, apply sterile pad if required, & make the patient comfortable.
xi. Discard the soiled swabs in the yellow bag & clean the equipments.
xii. Record the procedure as follows:
    a. Condition of vagina.
    b. Cervical dilatation
    c. Presenting part

d. Membranes intact or rupture.
e. Level or station of the presenting part.
f. Position
g. Molding
h. Pelvic is adequate

11. Fetal Heart Monitoring:

The fetal condition during labor can be assessed by obtaining information about the FHR & pattern; the fetal heart may be assessed intermittently or continuously.

11.1. Objectives:

i. To assess the baseline fetal heart rate.
ii. To detect any deviation from normal.

11.2. Responsibility:

Staff Nurse

11.3. Equipments/requirement

i. Doppler or sonic aid.
ii. Ultrasonic jelly.
iii. Tissue paper.

The following assessment of the FHR can be made:-

i. Rate: The rate should be between 120-160b/mt.
ii. Rhythm: The normal FHR has coupled beat which should remain steady. Any noticeable irregularity in the rhythm may give cause for concern.
iii. Presence or absence of acceleration / deceleration.

11.4. Procedure:

i. Explain the procedure to the client.
ii. Client should empty the bladder.
iii. Make the client lie on her back & provide privacy.
iv. Dry & warm hands before the procedure.

v. Using Leopold's maneuvers determine the fetal lie presentation & position.
vi. Apply adequate jelly to the Doppler.
vii. Place the Doppler on the maternal abdomen & locate the FHR.
viii. Monitor the FHR for one minute.
ix. Clean the area with tissue paper.
x. Make client comfortable.
xi. Replace the articles.
xii. Record the procedure.

12.Partogram:

It is chart on which the silent features of labor are entered in graphic form & therefore provides the opportunity for early identification of deviation from normal.

12.1. Responsibility:

Staff nurse

12.2. Aim:

To record the early features of labor which provides the basis for management as labor progress? The important features recorded in the partogram are as follows;

i. Fetal heart rate
ii. Maternal temperature
iii. Pulse
iv. Blood pressure
v. Details of vaginal examination
vi. Strength of contractions
vii. Frequency of contractions in terms of the number in 10minutes.
viii. Fluids administered
ix. Urine analysis
x. Drugs administered.

All these are recorded at 30 minutes interval.

13. Amniotomy (Artificial rupture of membrane):

Amniotomy is the artificial rupture of the fetal membranes resulting in drainage of liquor. It is commonly abbreviated as ARM.

13.1. Purpose:

i. To induce labor when the cervix is favorable.
ii. Augment contractions during labor.
iii. To visualize the color of liquor.

13.2. Responsibility:

Doctor/ Staff Nurse

13.3. Equipments/Requirement:

Sterile tray containing

i. Sterile gloves.
ii. Betadine solution
iii. Sterile cotton swabs
iv. Sterile bowls
v. Lubricating jelly
vi. Cocker's forceps
vii. Sterile pad

a) Doppler machine.
b) Kidney tray
c) Under sheet
d) Spot light

13.4. Procedure:

i. Explain procedure to the client & relatives.
ii. Instruct the client how she could assist with the procedure.
iii. Arrange the necessary equipments at the bedside.
iv. Provide privacy.
v. Wash hands.

vi. Check FHR before the procedure.
vii. Provide lithotomy position.
viii. Wear sterile gloves.
ix. Clean the area & perform P.V. examination.
x. The ARM should be carried out during contraction
xi. The cocker should be inserted & positioned with the non dominant hand puncture the sac during the peak of contraction.
xii. Take out the cocker & keep the finger inside the vagina until the liquor fully drain out & make sure that there is no signs of cord prolapse.
xiii. Observe the color & monitor the FHR.
xiv. Clean the area & make the patient comfortable.
xv. Clean & replace the articles.
xvi. Record the procedure.

14.Episiotomy:

This is an incision through the perineal tissues which is designed to enlarge the vulval outlet during the delivery.

14.1. Indications:

i. Primigravida with rigid perineum
ii. Malpresentation & Malposition.
iii. Occipito sacral face presentation Breech presentation.
iv. To speed delivery if the there is fetal distress.
v. Prior to an assisted delivery such as, forceps or vacuum delivery.
vi. To minimize the risk of intracranial damage during preterm & breech delivery.
vii. To prevent over stretching of the perineal muscle with intention of preventing the longer term problem of prolapsed & stress incontinence.
viii. To reduce the risk of spontaneous explosive trauma.
ix. Short perineum.
x. Narrow sub pubic arch, mild outlet contraction.
xi. Previous perineal laceration.

14.2. Types of Incision:

i. Mediolateral: Mid line of the posterior fourchette towards the ischeal tuberosity, far enough to avoid the anal sphincter. Usually 4 cm long, may reach the ischiorectal fossa when placed on the right, the introitus is widened slightly more. Most commonly used.
ii. Median: Incision is made from the fourchette almost up to but not through the external fibers of the anal sphincter.
iii. Lateral: Incision laterally on the perineum from the midpoint of the fourchette.

14.3. Timing of episiotomy:

Episiotomy must be given *just before crowning of head*

i. Perineum is bulging.
ii. 3-4cm fetal scalp is visible during the contraction.
iii. When the presenting part would be delivered during the next 3 to 4 contractions if too late, fails to prevent laceration. If too early there is unnecessary loss of blood

14.4. Layers cut in an episiotomy:

i. Skin & subcutaneous tissue.
ii. Bulbocavernosus muscle & fascia
iii. Transverse perineal muscle
iv. Rarely levator anus.
v. Vaginal mucosa.

14.5. Procedure:

i. Explain the procedure to the patient.
ii. Clean the area.
iii. Anesthesia local perineal infiltration with 1% Xylocaine & wait for 3-4minutes if possible.
iv. Placed two fingers in the vagina between the fetal head & perineum.
v. Episiotomy scissor is placed in such way that one blade is opposes the vaginal mucosa & the other the skin.
vi. During the strong contraction a single deliberate cut 4-5cm long is made at the correct angle.
vii. Delivery of the head should follow immediately & its advance must immediately control in order to avoid extension of episiotomy.

viii. If there is any delay before the head emerges pressure should be applied to the episiotomy site between the contractions in order to minimize the bleeding.

ix. PPH can occur from an episiotomy site unless bleeding points are compressed.

15. Episiotomy suturing:

15.1. Points to remember

i. Episiotomy to be sutured within one hour after the delivery.
ii. Tight pressure should be applied on the episiotomy incision soon after the delivery to minimize the bleeding.
iii. It is very important in the repair of the episiotomy that ascertains technique followed so as not to incur either dyspareunia or even a painful episiotomy.

15.2. Requirement/ equipments

A trolley contains:

i. Episiotomy suturing set.
ii. Syringe 10ml-1
iii. Needles-no 18g-1, 24g-1
iv. Inj. Xylocaine 1% Vial
v. Sterile gloves
vi. Suture material.

15.3. Procedure:

i. Explain the procedure to the patient.
ii. Provide privacy & give lithotomy position.
iii. Keep necessary articles at the bedside.
iv. The apex of the incision is identified & posterior vaginal wall is repaired from apex downwards, continuous sutures are applied to control the haemostatis.
v. The thread should not be pull too tightly as oedema will develop during 24-48 hours.

vi. Vaginal laceration which should also identified & to repaired.
vii. The deeper interrupted are then inserted to repair the perineal muscles.
viii. Good approximation of tissue is important.
ix. For skin closure a continuous subcuticular suture or interrupted transcutanneous suturing technique can be used.
x. Absorbable suturing material such as chromic catgut/ Vicryl/dexon are mostly use because they generally cause less pain & need less analgesia in the post partum period.
xi. The sutured areas should be inspected in order to confirm haemostasis before the procedure is completed.
xii. Vaginal examination is made to ensure that no gauze or cotton is left inside & the intriotus has not been narrowed.
xiii. Upon completion a rectal examination made in order to ensure that no sutures have penetrated the rectal mucosa, if so such suture must be removed to prevent fistula formation.
xiv. The area is cleaned & sterile sanitary pad placed.
xv. Provide comfortable position with legs close together.
xvi. Record the procedure.

16. Cardiotocography (CTG):

It is an electronic monitoring of fetal rate & rhythm; it can be recorded on a graph. It also includes monitoring of the strength & frequency of uterine contractions by means of an external transducer.

16.1. Purpose:

i. For the continuous & intermittent fetal heart monitoring.
ii. For monitoring the frequency, length & strength of uterine contractions.
iii. To identify the normal & abnormal FHR patterns.
iv. To evaluate & interpret the findings.

16.2. Indication:

i. **Fetal factors:**
   a) Decreased fetal movement.

b) Intrauterine growth retardation.
c) Oligohydramnios/ Polyhydramnios
d) Multiple gestations.
e) Fetal distress.

ii. **Maternal factors:**

a) PIH/Pre-eclampsia
b) Gestational Diabetes mellitus/ DM
c) Anemia
d) Prolong labour.
e) Post maturity
f) Previous L.S.C.S.
g) Previous Bad Obstetric/ Medical history
h) Chorioamniotis.
i) Prolong rupture of membrane.
j) Grand Multipara
k) Epidural analgesia.
l) Ante partum hemorrhage
m) Preterm labour.
n) Maternal fever.

16.3. Responsibility:

Staff Nurse

16.4. Requirement/equipments:

CTG machine contain

- Tocotransducer
- Ultrasonic transducer.
- Ultra sonic jelly.
- Two elastic belts.
- Tissue paper
- Graph paper.

16.5. Procedure:

i. Explain the procedure to the patient.
ii. Instruct her to empty the bladder.
iii. Provide privacy.

iv. Provide comfortable left lateral position.
v. Place two elastic belts around the abdomen.
vi. Put on the monitor; record all the information of the patient like Date, time, and name of the patient, IP / OP number and Doctors name.
vii. Using Leopold's Maneuvers Determine fetal position & presentation.
viii. Place the Toco transducer over the fundus of the uterus & secure it with belt so it fits snugly.
ix. Apply ultra sonic gel to the diaphragm of the ultra sound transducer & placed on abdomen & locate the FHR & secure it with belt.
x. Firm contact is necessary to maintain a continuous tracing.
xi. Avoid interruptions in between tracing.
xii. After completing the procedure the clean the transducer & replaced it proper place.
xiii. Clean the patient's abdomen & provide left lateral position.
xiv. Document the procedure & evaluate the report as follows:
    a. Baseline rate.
    b. Baseline variability
    c. Presence or absence of accelerations.
    d. Periodic or episodic decelerations.
    e. Number of contractions for 10 minutes.
    f. Overall assessment.

17. Perineal care:

17.1. Responsibility:

Staff nurse.

17.2. Purpose:

i. To decrease the growth of bacteria.
ii. To promote healing.
iii. To increase the patient comfort.
iv. To relieve pain.

17.3. Requirement:

A sterile tray containing:

i. Sterile bowl
ii. Sterile cotton swabs.
iii. Artery forceps.
iv. Sterile gloves.
v. Antiseptic solution.
vi. Kidney tray
vii. Sanitary pads
viii. Under sheet.

17.4. **Procedure:**

i. Explain the procedure to the patient.
ii. Provide privacy.
iii. Arrange the necessary equipments.
iv. Provide lithotomy position.
v. Spread under sheet under the patient buttocks.
vi. Wash hands & wear sterile gloves.
vii. Separate labia majora with one hand to expose the urethra & vaginal orifice.
viii. With the other hand holding artery forceps with cotton swabs clean the vulva & perineum using one swab for each stroke. (Clean area to unclean area).
ix. Check the condition of the episiotomy or tear & note for any swelling hematoma or any foul smelling discharge (Lochia).
x. Apply antiseptic ointment if ordered.
xi. Apply sterile pads.
xii. Remove the under sheet provide comfortable position.
xiii. Discard the soiled swabs & pads in red waste bin & replaced the articles.
xiv. Wash the hands & document the procedure.

18.Care of PIH Patient:

Pregnancy-induced hypertension is defined as the development of hypertension in a pregnant woman after 20 weeks gestation. The client diastolic blood pressure rises 25mmofHg above the base line or when the blood pressure rises above the 140/90mm of Hg. Oedema of the feet, ankles & proteinuria may be present.

18.1. Aim:

The ultimate aim is to prolong the pregnancy until the fetus is sufficiently mature to survive, While the safeguarding the mother's life.

18.2. Responsibility:

Staff Nurse and on duty Doctor

18.3. Care:

i. Provide calm & quite environment.
ii. Encourage to take adequate rest as much as possible.
iii. Monitor Blood pressure & pulse 2hourly.
iv. Check the weight daily.
v. Provide salt restricted, high protein, fibre & vitamin diet.
vi. A 10 minutes rest period is recommended before the monitoring the Blood pressure.
vii. Urine for ketone & albumin to be checked.
viii. Fetal assessment done by CTG, Fetal kick count chart, USG.
ix. Watch for oedema in the face, hands, Lower abdomen, pre-tibial region, ankles & feet.
x. Check for any complaints of frontal headache visual disturbances & epigastric pain with or without vomiting.
xi. Administer antihypertensive as ordered.
xii. Restrict the visitors.
xiii. Maintain fluids balance chart.
xiv. Observe for the signs of pre-eclampsia.

19.Preparation of the client for L.S.C.S.:

A Caesarian section In which the surgical incision (cut) is made in the lower segment of the uterus to deliver the baby. There is less muscles & more fibrous tissue, which reduces the risk of rupture in a subsequent pregnancy. Classical caesarean section is rarely performed.

19.1. Indications for elective L.S.C.S.:

i. Cephalopelvic disproportion.
ii. Major degree of placenta previa /Ante partum hemorrhage
iii. Multiple pregnancies.
iv. The primigravida & often the multigravida with breech presentation.
v. Moderate or severe pregnancies induced hypertension.
vi. Intrauterine growth retardation.

19.2. Indication for Emergency L.S.C.S.:

i. Cord prolapsed.
ii. Uterine rupture or scar dehiscence.
iii. CPD diagnosed in labor.
iv. Fetal distress, if delivery is not imminent.
v. Failure of progress in the first or second stage labor.
vi. Eclampsia

19.3. Responsibility:

Staff Nurse/ Doctor

19.4. Preparation

Explain the procedure & risk factors to the patient & relatives & then take written consent.

i. Provide psychological support.
ii. Keep NBM from 12mn for elective LSCS or 6 to 8 hours prior to surgery, the patient likely need LSCS only oral liquids are permitted.
iii. Check whether all the blood investigations ready. Cross match minimum I units of blood or as needed.
iv. Take pre anesthetic fitness.
v. Perform the skin preparation.
vi. Clothing & valuables to be handed over to the relatives.
vii. The bladder must be empty prior to LSCS this is achieved by inserting an indwelling catheter in to the bladder.
viii. Insert an IV line & start IV fluids as ordered.

ix. Pre medication is administered as per doctor's order.
x. Complete preoperative check list.
xi. Any ornaments which cannot be removed are covered with adhesive tape.
xii. Remove nail polish.
xiii. Monitor vital signs including FHR & recorded.
xiv. Check whether the OT clearance slip submitted.
xv. Send the patient to OT on call.

20.Postnatal care:

Post natal or postpartum is the period beginning immediately after birth of child and extending for about 6 weeks, during which the continued attendance of midwife on the mother and child is requisite.

20.1. Principles:

i. Promoting physical & psychological well being of the mother & her baby & the family unit.
ii. The identification of deviation from normal physiological & psychological progress with appropriate prompt referred where required.
iii. Encouraging sound method of infants care & feeding & promoting the development of effective parent infant relationship.
iv. Supporting & strengthen the woman & her partner's confidence, thus facilitating their transition to the parenting role within their particular family.

20.2. Responsibility:

Staff Nurse

20.3. Care:

i. Check vital signs. During the first 24hours the temperature will be slightly elevated.
ii. Assess & check for bleeding.
iii. Assess whether the uterus contracted & involuting well.
iv. Make sure the bladder is empty.
v. Promote breast feeding & instruct mother about the care of breast.
vi. Promote early mobilization.

vii. Practice rooming in.
viii. Teach postnatal exercise.
ix. Encourage personal hygiene.
x. Administer analgesics as per order.
xi. Give night sedation if needed.
xii. Promote postnatal nutrition.
xiii. Observe for the signs of infections.
xiv. Control of visitors and provide safe environment.
xv. Review lab values.
xvi. Administer Anti-D if required within 72 hrs.
xvii. Instruct her about the importance of postnatal checkup.
xviii. Immunize the baby as per hospital protocol.
xix. Birth registration to be completed before discharge.
xx. Instruct her about the importance of family planning

21. Placenta Praevia:

The placenta is partially OR wholly implanted in the lower uterine or segment on either the anterior or posterior wall.

21.1. Degrees of placenta praevia:

Type 1: The majority of the placenta is in the upper uterine segment. Vaginal is delivery possible, blood loss is usually mild & the mother & fetus remain in good condition.

Type 2: The placenta is partially located in the lower segment near the internal cervical os (marginal placenta praevia) vaginally delivery if possible particularly if the placenta is anterior. Blood loss is usually moderate

Type 3: the placenta is located over internal cervical os but not centrally. Bleeding is lightly to be severe particularly when the lower segment stretches & cervix benign to efface & dilate in late pregnancy. Vaginal delivery is impossible

Type 4: Placenta is located centrally over the internal cervical os, vaginal delivery should not be considered LSCS is done to save lives of the fetus & mother.

21.2. Responsibility:

Staff Nurse

21.3. Nursing care:

It depends upon the following

i. The amount of bleeding
ii. The condition of the mother and fetus.
iii. The location of the placenta.
iv. The stage of the pregnancy.

21.4. Conservative management:

i. Provide complete bed rest in left lateral position (slightly head low position)
ii. Monitor vital signs
iii. Observe for the bleeding (mild/ moderate/ severe)
iv. Assess fetal condition by CTG.
v. Do not perform vaginal examination; speculum examination is carried out if needed.
vi. Review all lab values & x-match 2-4 units of blood
vii. Save the pads to assess the bleeding
viii. USG is done to assess the fetal growth and the position of the placenta.
ix. Provide high protein diet
x. Instruct the mother to take antenatal vitamins.

21.5. Active management:

i. Severe vaginal bleeding will require immediate delivery by LSCS, regardless of the location of the placenta.
ii. High risk consent should be taken.
iii. PPH is anticipated, so the nurse should be prepared to meet the emergency

22. Management of the 1st Stage of Labor:

The 1st stage begins with regular rhythmic contraction & is completed when the cervix is fully dilated.

22.1. Responsibility:

Staff Nurse/ on duty Doctor

22.2. Nursing management:

i. **Provide a calm and quiet environment**: Anxiety will affect the woman's perception and understanding, therefore it is essential that the labouring woman is welcomed and encouraged to feel at ease and that the nurse spends time actively listening as the woman recounts the details of the onset of labor.
ii. **Emotional support**: Explain the procedure to the patient. Nurse must provide support by giving information which encompasses ensuring that the woman understands events, feels free to ask questions and is aware of how labor is progressing.
iii. Provide adequate privacy.
iv. **Position and mobility**: Encourage the woman to lie in left lateral position, these aids in good fetal circulation.
v. **Nutrition**: The client who is in labor can have foods such as toast, yogurt, fruit juice, tea , plain biscuits and clear soup which is easily digested.(liquid diet is preferred unless contraindicated).encourage the client to take plenty of oral fluids.
vi. **Bladder care**:-the woman should be encouraged to empty the bladder every 2hourly during labor. If the client is in epidural analgesia offer a bed pan or insert a plain catheter to empty the bladder, full bladder may prevent the decent of the fetal head.
vii. **Observations:-**
    a) Check vital signs and FHR.
    b) Fluid balance should be maintained either by oral intake or by IV fluids.
    c) Contractions-frequency, length and of contractions should be noted. Contractions which are unduly long or strong and in quick in succession give cause for concern as fetal hypoxia may develop.
    d) If CTG is in progress and the contractions are not properly recorded then the nurse should place her hands on the fundus and feel for the strength of uterine contractions.

Vaginal examinations:-it is not essential to examine the woman per vaginally at frequent intervals, it may be useful to do so when progress is in doubt or another indication is arising.

23. Management of Second Stage of Labor:

The second stage of labor begins when the cervix is fully dilated and ends with the baby's birth.

23.1. Responsibility:

Staff nurse

23.2. Presumptive signs

i. Expulsive uterine contractions.
ii. Rupture of the fore waters if not ruptured early.
iii. Dilatation and gaping of the anus.
iv. Appearance of the presenting part.
v. Excessive show.
vi. Congestion of the vulva

Mechanism of labor please refers the guidelines.

24. Observations During Second Stage of Labor:

i. **Uterine contractions**
   The strength, length and frequency of contractions
ii. **Progress of descent**
iii. **Fetal condition**
   FHR monitoring.
   Liquor for meconium stain
iv. **Maternal condition**
   a. Pulse, BP, respirations
   b. Hydration: - oral fluids / IV fluids.

24.1. Requirements

Delivery pack

Sterile linen pack:

i. 2 sterile gowns.

ii. Leggings for the patient.
iii. Perineal sheet.
iv. Under sheet.
v. One big drape.
vi. Small green towel.
vii. Betadine solution.
a. Inj. Xylocaine 1%.
b. 10" syringe – 1.
c. Needle no: - 22G, 20 G.
d. Sterile cotton swabs, gauze, pads.
e. Sterile gloves.

24.2. Procedure

i. Explain the mechanism of labor to the client.
ii. Provide privacy.
iii. Start Oxytocin if contractions are inadequate at the onset of the 2nd stage.
iv. Provide lithotomy position or encourage the woman to adopt any other position that she finds most comfortable.
v. Inform her that in this stage she will be guided by her own urge to push.
vi. Encourage her to empty the bladder / insert plain catheter if needed.
vii. Inform her that if pushing is ineffective, strategies to assist birth such as support, change of position and encouragement are used.
viii. All observations should be documented in the partogram.
ix. Monitor FHR continuously(baseline rate is between 120-160b/min)
x. When the presenting part is slightly visible and not receding back clean and drape the part.
xi. When the perineum is bulging the nurse should place her fingers on the advancing head to monitor descent and prevent expulsive crowning to prevent lacerations.
xii. Episiotomy is performed if needed.
xiii. A light pressure on the head is maintained so that its birth is controlled.
xiv. Instruct the mother to control her pushing by gently blowing out each breath to avoid sudden pushing.
xv. Once the head is crowned it is born by extension.
xvi. Check whether the cord is around the neck, if so and it is loose slip the cord, if it is tight clamp and cut the cord.

25.Breast Feeding:

25.1. Responsibility:

Staff Nurse

25.2. Advantages of breast feeding:

i. It establishes bonding between mother & baby.
ii. It provides perfect nutrition.
iii. IT maximizes child's physical & intellectual potential.
iv. It provides initial immunization.
v. It prevent diarrhea.
vi. It promotes the recovery of the sick child.
vii. It supports food security.
viii. It is environment friendly.

25.3. Points to remember:

i. Breast feeding should be started within 30minute after the delivery.
ii. Burping should be done after every breast feed.
iii. The baby should be fed from each breast on regular intervals.
iv. Breast feed should be given on demand.
v. Teach the mother how to prevent the breast engorgement & crack nipples.
vi. If the baby is in NICU teach her how to maintain the lactation by expressing the milk.
vii. Instruct the mother to watch for feeding cues.
viii. Encourage mother to take adequate fluids & nutritional diet to maintain lactation.
ix. Instruct the mother to wear proper size brassieres to provide support to the breast.
x. If the baby is not alive/ IUFD lactation is suppressed as per the Doctor's order.

25.4. Procedure:

i. Explain the procedure.
ii. Instruct the client to wash the hands.
iii. Provide privacy.
iv. Encourage her to relax & tension free.

25.5. Positions:

ii. Bird modified vacuum set.
iii. Syringe 10cc-1
iv. Needles-18g & 24g
v. Sterile vacuum tubes.
vi. Suction machine.

26.3. Prerequisites for Vacuum delivery:

i. Head must be engaged.
ii. Cervix must be fully diluted.
iii. Membranes should be ruptured.
iv. Position of the head must be known.
v. Patient should be adequate local anesthesia.
vi. Adequate facilities & supportive element should be available.

26.4. Procedure:

i. Explain the procedure to the client.
ii. Provide adequate privacy; put the patient on lithotomy position.
iii. Make sure the bladder is empty.
iv. Clean & drape the area.
v. Give local anesthesia.
vi. The position of the fetal head is determined & appropriate size & type of cup selected.
vii. The cup is placed against the fetal head as near to the occiput as possible, ensuring that the no cervix is trapped beneath it. Partial pressure of 0.2 kg/cm is attained.
viii. The vacuum is then built up to a negative pressure 0.8kg /cm in one step.
ix. Once this pressure has been obtained, the operator waits 1-2 minutes for a chignon to form then exerts steady gentle traction on the fetal head along with uterine contraction & mother's expulsive efforts.
x. Episiotomy is given if necessary.
xi. Nurse should give the perineal & paraurethral support to prevent the tears.
xii. As the head is delivered suction is released & a cup is removed.
xiii. This procedure should be discontinued if one fails to achieve extraction after 10 minutes of maximal pressure. No progress is made after three pulls.

26.5. Failure of vacuum extraction:

i. **Lying on her side:** This position may be appropriate if she hand LSCS or perineum is very painful, this is the only position she can tolerate in the first few days after delivery. She will need assistance in placing the baby at the breast because it will be difficult for her to manipulate him skillfully.
ii. **Sitting up:** In this position the mother back should be upright & at a right angle to her lap, if needed pillow should be placed at the back & on the lap.
iii. **Positioning the baby's body:** The baby's body should be turns towards the mother body. If the bay's nose is opposite the nipple before he bought to the breast & neck is slightly extended, the baby's mouth will be in the correct relationship to the nipple.
iv. **Attaching the baby to the breast:**
    a. The baby should be supported across his shoulder, so that slight extension can be maintained
    b. .The head may be supported by the extended fingers of the supporting hand or on the mother's forearm.
    c. If the baby's mouth is moved gently but persistently against the mother's nipples he will open his mouth wide.
    d. As he grasps he is moved quickly to the breast. This allows the baby to draw breast tissue as well as nipple into his mouth with his tongue.
    e. If correctly attached the baby will have formed a 'teat' from the breast & the nipple. If the baby is well attached minimal suction is required & its prevent air entry into the baby's mouth.

26.Vacuum extraction (Ventouse delivery):

The Ventouse or vacuum extractor consists of a cup which is attached to the fetal scalp by suction, & the means of providing the vacuum. If correctly positioned it brings about flexion of the head & natural rotation.

26.1. Indication:

i. Mild fetal distress.
ii. Delay in the second stage of labour.
iii. Malposition.
iv. Maternal exhaustion

26.2. Articles:

i. Delivery set.

i. Faults in equipment.
ii. Improper application of traction.
iii. Improper selection of cups size.

26.6. Complications:

i. Failure
ii. Maternal trauma.
iii. Fetal:
   a. Chignon: This is an area of oedema & bruising where cup was applied.
   b. Cephalhaematoma:
   c. Cerebral trauma: Such as tentorial tear.

27.Forceps' delivery:

Forceps delivery is a means of extracting the fetus with the aid of obstetric forceps when it is in advisable or impossible for the mother to complete the delivery by her own effort. Forceps can be used to assist the delivery of the after coming head of the breech & on occasion to withdraw the head up & out of the pelvis in LSCS.

27.1. Indications:

27.1.1. Maternal:

i. Exhaustion
ii. Prolong second stage.
iii. Maternal illness such as heart disease & hypertension.
iv. Drug related analgesia.

27.1.2. Fetal:

Non reassuring CTG

27.2. Types of forceps:

i. Wrigley's forceps (Outlet forceps)
ii. Simpson's forceps (Low cavity forceps)
iii. Neville-Barnes Forceps (Midcavity forceps).

iv. Kielland's forceps.

27.3. Prerequisites for forceps delivery:

i. Head must be engaged.
ii. Membrane should be ruptured.
iii. Cervix should be fully diluted.
iv. Position of head must be knows.
v. No appreciable CPD.
vi. Patient should be adequate local anesthesia.
vii. Adequate facilities & supportive element should be available.

27.4. Articles:

i. Delivery set.
ii. Syringe 10cc-1
iii. Forceps as required.
iv. Needles-18g & 24g
v. Lubricating jelly
vi. Xylocaine – 1%

27.5. Procedure:

i. Explain the procedure to the client.
ii. Provide adequate privacy; put the patient on lithotomy position.
iii. Make sure the bladder is empty.
iv. Clean & drape the area.
v. Give local anesthesia.
vi. The lubricating jelly is applied to the blades & left blade is introduced initially, to the left side of pelvis & the right blade in to the right side of pelvis, the forceps then locked without pressure.
vii. Episiotomy is given if needed when the perineum is distended.
viii. The nurse should give the perineal & paraurethral support to avoids the tears.
ix. As soon as the doctor is ready & the uterus contracts the mother is encourage to push then the doctors exerts steady, downwards traction on the forceps.
x. Traction is released between contractions. FHR monitored carefully.

xi. Intermittent traction is continued in a downward & backward direction until the occiput is felt below the symphysis pubis & the head is delivered as in a normal delivery.
xii. Third stage management & nursing management is same like normal delivery.

28.Epidural Analgesia:

The term "epidural" is used in reference to both analgesia (diminishment or total relief of pain) and anesthesia (total absence of sensation) that is produced by injecting local anesthetics and/or opoid (natural or synthetic narcotics) into the epidural space surrounding the spinal column.

28.1. Method

i. Epidural analgesia is accomplished by introducing a relatively large needle into the epidural or peridural space between the lumbar vertebrae and pushing a catheter through the needle into the epidural space.
ii. The large needle is then withdrawn, and the catheter is left in place.
iii. Local anesthetic solution is administered through the catheter, either as an initial dose with injection of additional medication as needed or at regular intervals, by use of a pump that provides a slow continuous infusion throughout labour, or through use of equipment by which the woman controls the dose she receives, with safeguards to prevent too frequent doses (commonly referred to as PCEA or patient controlled epidural anesthesia).
iv. During initial insertion of the needle and catheter the woman is assisted to curl her body forward while she is either sitting up or lying on her side.
v. The area is cleansed with antiseptic solution and numbed with local anesthetic injected with a small needle then the large needle is introduced, through which epidural catheter is passed and bolus dose is given.
vi. The catheter is fixed and continuous infusion is started.

28.2. Indications

i. Pain
ii. Pre-eclampsia

iii. High risk fetus group
iv. Breech delivery/ twin delivery
v. Trial of prolonged labour
vi. Patient request
vii. Symptomatic heart disease
viii. Respiratory disease
ix. Cerebrovascular disease
x. Abnormal or dead fetus
xi. Inco-ordinate uterine action

28.3. Prerequisites for epidural analgesia

i. Maternal consent is required
ii. Progress of labor is assessed that is cervical dilatation should be 3 cm and above
iii. Maternal /fetal status to be assessed.
iv. I.V. cannula is inserted and infusion is started.

28.4. Articles

Epidural set containing.

i. Medium sterile tray - 1
ii. Sterile bowls – 2
iii. Sponge holder – 1
iv. Small scissor (optional)
v. Sterile gown.
vi. Slit towel.
vii. Hand towel.
viii. BD Epidural set with or without syringes.
ix. Syringe 2",5",10",50".
x. Needles 24g, 18g, and 26g.
xi. 2% Xylocaine.
xii. Soft care and Betadine solution.
xiii. Normal saline ampoules – 5
xiv. Sterile gloves – 2
xv. Surgical mask.

28.5. Commonly used drugs

i. Inj.Lidocaine 1-2%.

ii. Inj. Bupivacine 0.25 – 0.75%
iii. Inj. Fentanyl 2 ml.

28.6. Position:

The patient must be sitting lateral position. The sitting patient asked slouch & bend forward slightly from the waist to increase the curvature of the spine.

28.7. Procedure:

i. Explain the procedure to the patient & relative.
ii. Anesthetist should go for surgical hand wash, wear sterile gloves & gown.
iii. Give the proper position as per explaining.
iv. Clean & drape the client back.
v. Then anesthetist palpates the patient back & identifies a suitable anatomical gap between the bony spinous processes prior to procedure.
vi. Then local anesthesia given at selected site.
vii. The commonly anesthetist conduct epidural places the catheter in the lumber or lower back region of the spine.

28.8. Nursing care during epidural infusion:

i. During the care of the pregnant woman the registered nurse may:
   a. Monitor the mother and the fetus.
   b. Stop the infusion.
   c. Initiate emergency therapeutic measures under protocol if complications arise.
   d. Remove the epidural catheter.
ii. A qualified, credentialed, licensed anesthesia care provider is responsible for:
   a. Insertion of the epidural catheter.
   b. Initial injection and/or initiation of a continuous infusion of analgesia
   c. Rebolus of an epidural catheter.
   d. Increasing and decreasing the rate of the continuous infusion.
iii. Call C.P.R. team if needed.
iv. Maternal hypotension: Position mother in lateral position, administer IV fluid bolus as ordered, and notify anesthetist and/or primary care provider.
v. Continue to evaluate maternal pain levels with ongoing patient assessments. Assess for purities if an ovoid was given.
vi. Bladder distension caused by a decrease in the woman's sensation to void may be a side effect of epidural anesthesia. The bladder should be palpated regularly, and she should be encouraged to void. Intermittent

catheterization or a Foley's catheter may be needed if the woman's bladder is distended and she is unable to void.

vii. Epidural may be removed post recovery period by an OB nurse unless otherwise ordered. Nurse to document removal and verify that black tip is intact.

29. Administration of Vaginal Peccary:

29.1. Purpose

i. To administer medications locally.
ii. To treat vaginal infections.

29.2. Responsibility:

Staff Nurse

29.3. Points to remember:

i. Please refer nursing guidelines for all practical procedure.
ii. Please refer guidelines for drug administration.

29.4. Requirements:

i. Clean gloves.
ii. Dry swabs in a ball.
iii. Applicator / introducer.
iv. Lubricating jelly.
v. Suppository / vaginal pessary as prescribed.
vi. Sanitary pad.
vii. Under sheet.

29.5. Procedure:

i. Explain the procedure to the patient.
ii. Check patient's history for allergies.
iii. Assist or ask the patient to clean the perineal area.

iv. Wash hands. Encourage patient to wash hands, if she is able to insert pessary herself.
v. Assist the patient to lie in dorsal recumbent position.
vi. Wear clean gloves and apply lubricating jelly to the applicator, place pessary to applicator.
vii. Introduce applicator slowly and gradually holding the labia apart. Once in position depress the plunger to release the pessary.
viii. Dispose of waste, remove gloves and wash hands.
ix. Instruct the patient to remain on back for at least 10 min.
x. Provide sanitary pad if needed.
xi. Record the procedure.

a. Wait for the restitution and external rotation of the head ,once these occur place the hand each side of the baby's head ,apply downward traction ,this allows the anterior shoulder to slip beneath the symphysis pubis while the posterior shoulder remains in the vagina.
b. When the axillaries cresses are seen the head and trunk are guided in an upward curve to allow the posterior shoulder to escape over the perineum.
c. The doctors grasp the baby around the chest and lift the baby towards the mother's abdomen.
d. The nurses clean the baby and assist the pediatrician in providing new born care.

30.Management Of Third Stage of Labor:

The third stage is that of separation and expulsion of placenta and membranes and also involves the control of bleeding. It lasts from the birth of the baby until the placenta and membranes have been expelled.

30.1. Active management of the third stage includes 3 components:

i. Use of uterotonic drugs
ii. Clamping and cutting the cord
iii. Controlled cord traction

30.2. Responsibility:

30.3. Procedure:

i. Clamp the umbilical cord immediately following birth of the baby.
ii. Collect cord blood for baby group Rh.
iii. Observe for the signs of placental separation like:
- Lengthening of the cord.
- A gush of blood.
- The uterus becomes hard and mobile.

a. Massage the uterus per abdomen to make it contracted.
b. Counter traction (one hand is placed above the level of symphysis pubis with the palm facing towards the umbilicus exerting pressure in an upward direction) is applied to remove the placenta.
c. The other hand firmly grasping the cord, applies traction in a downward and backward direction following the line of birth canal.
d. Some resistance may be felt but apply steady tension by pulling the cord firmly maintaining the pressure.
e. Jerky movements and force should be avoided.
f. If the maneuver is not successful pause for a while wait for the next uterine contraction and further attempt is made.
g. Once the placenta is visible it may be cupped in hands to ease pressure on the friable membranes.
h. Once the placenta and membranes expelled administer Inj.methergin 2 amp(0.4mg)
i. IV as per doctors order

Date : 11/06/2024

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