STANDARDS-BASED MANAGEMENT AND RECOGNITION FOR IMPROVING QUALITY IN MATERNAL AND NEWBORN CARE

INTEGRATED QUALITY IMPROVEMENT STANDARDS

ASSESSMENT TOOL

Introduction to Standards-Based Management and Recognition

SBM-R is a practical management approach to improve the performance and quality of health services. SBM-R consists of: 1) the systematic utilization of performance standards as the basis for the organization and functioning of these services, and 2) the rewarding of compliance with standards through recognition mechanisms. SBM-R follows four basic steps:

- Setting standards of performance in an operational way
- Implementing the standards through a streamlined and systematic methodology
- Measuring progress to guide the improvement progress towards these standards
- Recognizing achievements

This process begins with the development of evidence-based operational standards in a specific area of health delivery, in this case, maternal and newborn care. The performance standards developed are included in the assessment tool and can be used for self, peer, internal and external assessment at the facility level.

Figure 1: Cycle of Performance Improvement

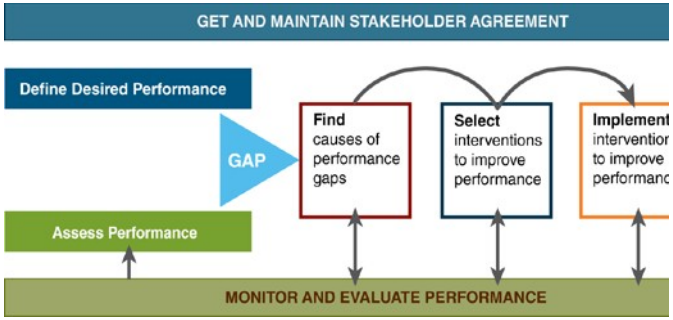

Figure 2: Implementation Cycle

The implementation of the assessment tool leads to the identification of performance gaps that need to be reduced or eliminated. Local health managers and providers then analyze the causes of the gaps and identify and implement appropriate interventions to correct them—for example, a lack of knowledge and skills, an inadequate enabling environment (resources and policies, etc.) or lack of motivation to close these gaps.

Local health authorities are encouraged to focus on action and begin with simple interventions (the “low hanging fruit”) in order to achieve early results, create momentum for change and gradually acquire change management skills to address more complex gaps.

Partial improvements are rewarded during the process using a combination of measures, including feedback and social recognition (e.g., ceremonies, symbolic rewards). The global achievement of compliance with standards by the facility is acknowledged through a mechanism that should involve institutional authorities and the community.

Description of the Assessment Tool :

The performance assessment tool:

- Lists key performance standards organized by area of program support.
- Includes verification criteria for each performance standard that is easily observable with "Yes" (Y) "No" (N) and "Not Applicable" (N/A) answer options. (Where there are a lot of verification criteria these may be detailed on another page).
- Objectively establishes the desired level of performance.
- Measures actual level of performance when applied to a facility or institution.
- Helps identify performance gaps.
- Prioritize action points and monitor over time to improve performance

In this tool, there are four areas and a total of 40 standards.

S. NO.	AREAS
1	Normal Labour and Delivery including Immediate Newborn Care
2	Management of Antenatal, Intrapartum and Postpartum Complications
3	Postnatal Care for the woman and the neonate
4	Infrastructure and Human Resources

How to Use the Assessment Tool:

The assessment tool should be used to conduct assessments in the facility. In each area, the standards have specific instructions about how and where to collect/verify the information needed, and the number of observations required. The three methods of data collection are: 1) direct structured observation, 2) document review and 3) interviews or clinical simulations.

When using *direct structured observation*:

- Introduce yourself and explain the reason for the assessment
- Use the assessment tool to guide the observation
- Do not provide feedback during the assessment
- Be objective and respectful during the assessment

When doing *document review*:

- Introduce yourself and explain the reason for the assessment
- Identify correct sources of information (e.g., administrative forms, statistical records, service registers/reports/records)
- Review the documents using the assessment tool
- Question individuals responsible for these areas to complement and or clarify information
- Be objective and respectful during the assessment

When conducting *interviews or observing clinical simulations*:

- Introduce yourself and explain the reason of the assessment
- Identify the staff that typically carries out the activities or procedures
- Interview the staff using the assessment tool
- Probe to get precise information; do not assume responses
- Ask the person to show documents, equipment or materials as appropriate
- Be objective and respectful during the assessment

How to fill out the assessment tool

Immediately register the information collected.

- Register “Y,” “N” or “NA” in the corresponding column. Do not leave any verification criteria blank
- Register “Y” if the procedure is performed or item exists as it is described
- Register “NA” when the required condition does not exist or when the verification criteria can be assessed by an alternative method
- Register “N” if the procedure is not performed or not performed correctly

How to score the assessment tool

Scoring using the assessment tool:

- Each standard is worth one point
- For each standard to be met, all of the verification criteria should be “Yes” or “Not Applicable”

In the example below, the first verification criteria is "Y" because during the observation the provider checked to see if the placenta is complete. In the same example, the fourth verification criterion is "NA" because the required condition did not exist (there was no tear to repair).

STANDARD	VERIFICATION CRITERIA	Y, N, NA	COMMENTS	Score
The provider adequately performs immediate postpartum care	Observe two women during a delivery and determine whether the provider (in the labour or delivery rooms):			1
	Checks to see whether the placenta is complete (maternal and foetal sides, plus membranes)	Y		
	Informs the woman what she is going to do before proceeding, then carefully examines the vagina and perineum	Y		
	Gently cleans the vulva and perineum with clean water (warm, if possible) or a non-alcohol antiseptic solution.	Y		
	Sutures tears if necessary	N/A		
	Covers the perineum with a sanitary pad	Y		
	Ensures that the baby is well covered, is with the mother and has begun to suckle	Y		

In the example below, the site was awarded 0 points because the second verification criterion was not met.

STANDARD	VERIFICATION CRITERIA	Y, N, NA	COMMENTS	Score
The provider adequately performs immediate postpartum care	Observe two women during a delivery and determine whether the provider (in the labour or delivery rooms):			0
	Checks to see whether the placenta is complete (maternal and foetal sides, plus membranes)	Y		
	Informs the woman what she is going to do before proceeding, then carefully examines the vagina and perineum	N		
	Gently cleans the vulva and perineum with clean water (warm, if possible) or a non-alcohol antiseptic solution.	Y		
	Sutures tears if necessary	Y		
	Covers the perineum with a sanitary pad	Y		
	Ensures that the baby is well covered, is with the mother and has begun to suckle	Y		

How to summarize the results:

- Summarize the results using the summary table at the end of each area and fill the details in the summary sheet
- Write the number of standards achieved per area and in the row of total in the summary sheet
- Calculate and write the percentage of standards achieved per area and in total by dividing the number of standards achieved by the total number of standards in each area, and multiplying the results by 100 (e.g. 6/12 x 100 = 50%). Apply the same process for the general total, divide total number of standards achieved by the total number of standards (e.g. 25/50 x 100 = 50%). Fractions of percentages (e.g., 27.67%) have limited value and are not statistically significant so round up or down (e.g., 28%)

S.No.	AREAS	NUMBER OF STANDARDS	NUMBER OF STANDARDS OBSERVED	STANDARDS ACHIEVED	
				NUMBERS	%
1	Normal Labour and Delivery including Immediate Newborn Care	18			
2	Management of Antenatal, Intrapartum and Postpartum Complications	7			
3	Postnatal Care for a woman and the neonate	8			
4	Infrastructure and Human Resources	7			
TOTAL		40			

Usually for the facility to obtain recognition, it should reach at least 80% compliance with the standards overall

Types of Assessments

A baseline assessment and then continuous measurement of progress is used as a mechanism to guide the process, inform managerial decisions and reinforce the momentum for change. Through continuous measurement, managers, providers and communities can monitor progress, assess success of intervention, identify gaps and introduce necessary adjustments to their plans. Measurement makes it possible to present managers and providers with quantitative targets. Achieving and making sustainable progress against these targets has an important motivating effect for those involved in the improvement process.

Continuous measurement is based on the implementation of *periodic assessments* using the performance assessment tool. The assessments can be:

- **Self-assessments** conducted by individual providers on their own work. The provider uses the performance assessment tool as a job aid to verify if she/he is following the recommended standardized steps during the provision of care. These assessments can be conducted as frequently as desired or needed.
- **Internal assessments** implemented internally by facility staff. Internal assessments can be performed by a group of colleagues or health facility staff using the tool to assess the work among themselves (i.e., "peer assessment"). Internal assessments can also be conducted by managers/supervisors using the tool to periodically assess the service being improved. It is recommended this type of assessment to occur every three to four months.
- **External assessment**s implemented by an assessor who is external to the health facility. These assessments are usually conducted by central, regional and district level of Ministry of Health. They can be conducted in the form of facilitative supervision when the purpose of the visit is to provide support for identification of performance gaps and interventions.

Verification assessments occur when the purpose of the visit is to confirm compliance with recommended standards of care for recognition. In case of verification assessment, it is desirable that representatives of the clients and communities served are involved in the process in an appropriate way.

Development of Action Plans and Organization of Teams

After every assessment, the facility staff should develop operational plans to guide implementation of the improvement process. These plans are relatively simple tools that outline the gaps and their causes that need to be eliminated, the specific intervention to be conducted, the persons involved, the timeframe for the task and any potential support that may be needed. The identification of the responsible persons and the setting of the timeframe are extremely important because they allow better follow-up of activities in the

plan. Operational plans should be developed upon analysis of the results of the baseline or follow-up monitoring assessments by the team of facility providers and managers working in different areas of service provision being improved.

It is important to understand that the process is usually initiated by a small group of committed persons because it is uncommon to find immediate widespread support for new initiatives. Therefore, it is important to find those committed persons for the initiative and incorporate them in the initial improvement efforts.

A key task of the initial group of committed persons is to organize teams to implement the improvement process. Most service delivery processes depend on team efforts rather than a single provider; therefore, it is important to expand the group of committed people beyond champions. Teams should be organized by specific area of the assessment tool. Each area team should analyze the results of the performance assessment in their respective area, develop an operational plan accordingly and implement and monitor improvement activities.

It is recommended to work with a network of services/facilities rather than implementing the process in isolation. Working within a network of similar services or facilities promotes an exchange of experience and provides mutual support, thus supporting the achievement of positive changes.

The process emphasizes bottom-up action, client and community involvement. A key purpose of the SBM-R process is to provide local health workers, managers and the community in which they serve with practical tools to empower them and increase their ability to strengthen the health service delivery process.

In addressing the identified gaps, the teams should remember that there are gaps that:

- Do not require significant cause analysis because the solution is simple and obvious (e.g., designation of a person in charge of a task, replacing broken equipment, relocation of supplies and equipment to make them more available at point of use).
- Are caused by factors under local/facility control and could be eliminated with the mobilization of local resources (e.g., modification of some internal procedures, redistribution of workload within the facility, internal reallocation of resources, establishing continuing education program in a facility, implementation of some kind of incentives).
- Are caused by factors that are outside the local/facility control and usually require the mobilization of significant external resources (e.g., change of policies, salary increase, staff hire to increase manpower, provision of additional budgets, physical plant remodeling/construction).

As mentioned earlier, teams should begin with the easier gaps and gradually undertake the more complex gaps.

SUMMARY SHEET

REGION: _____

DISTRICT: _____

FACILITY NAME: _____

TYPE OF FACILITY: MC, DH, SDH, RH, CHC, PHC, SC (Circle the appropriate response)

ASSESSMENT TYPE: (Circle the appropriate response) BASELINE/INTERNAL/EXTERNAL

ASSESSORS: _____

DATE: _____

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ACTION PLAN

STANDARD/GAP	CAUSE	INTERVENTION	RESPONSIBLE PERSON	SUPPORT REQUIRED	TIMELINE
1.					
2.					
3.					
4.					

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2.					
3.					
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Integrated Performance Standards for Maternal and New born Care

Area 1: Normal Labour and Delivery including Immediate New born Care

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
NLD 1: The provider prepares equipment, supplies and the environment to conduct clean and safe deliveries		1. Makes sure that the delivery room is cleaned (free of dust, cobwebs, blood, other secretions) according to standard procedure								
		▪ Cleaning personnel must use utility gloves, mask, plastic/rubber apron, protective eyewear and shoes								
		▪ Floors are wet mopped with a disinfectant solution (0.5% chlorine solution + soap)								
		▪ Walls are cleaned with a clean cloth or mop wet in a cleaning solution								
		▪ Chairs, lamps, tables, tabletops, lights, top of doors and counters must be wiped with a damp cloth, containing disinfectant cleaning solution								
		▪ Non-critical equipment (e.g., stethoscope and blood pressure cuffs) must be wiped with a damp cloth with water and								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		detergent; if the equipment is visibly soiled with blood or body fluids or the patient is under contact precautions, it must be cleaned and disinfected before reuse								
		2. Checks and looks for supplies and equipment to conduct clean normal deliveries								
		a. A sterile Delivery –Set containing								
		▪ Sterile tray								
		▪ Two haemostats (clamps) artery forceps								
		▪ One scissor for cutting the cord								
		▪ One cord clamp or sterile tape or sterile tie								
		▪ Two pre warm towels for baby AND Drapes for mother								
		▪ One receiver/kidney tray for placenta								
		▪ Sterile gauze to clean baby's mouth and nose								
		▪ Sterile swabs for cleaning eyes								
		▪ pairs of sterile gloves								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		3. One leak-proof container (2 * 3 feet plastic tub) with 0.5% chlorine solution for decontamination								
		4. One leak-proof container with a yellow plastic bag and bleaching. powder to dispose the placenta and medical waste like soiled dressing material								
		5. One sharps disposal Hub Cutter at point of use to dispose of needle and Red Plastic bag for syringes								
		6. One leak-proof container to dispose of soiled linen								
		7. One 2 ml syringe loaded with Oxytocin 10iu for each delivery								
		8. Personal Protective equipment (PPE) (cap, mask, shoe covers, gloves, plastic apron, goggles)								
		9. Drapes for mother								
		10. 2 warm towels for drying and wrapping baby								
NLD 2: The provider performs a quick check and rapid initial assessment of		Observe the provider to determine if s/he assesses each woman individually on arrival as follows:								
		1. Determines if birth is								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
the pregnant women in labour to identify complications and prioritize care		imminent (desire to bear down, crowning, regular strong uterine contractions)								
		2. Asks the pregnant woman upon her arrival in the hospital whether she has or has had any of the following danger signs:								
		▪ Vaginal bleeding								
		▪ Severe difficulty breathing								
		▪ Fever								
		▪ Severe abdominal pain or looks very ill								
		▪ Convulsions or unconscious								
		▪ Severe headache/blurred vision								
		3. Assures immediate attention in the event of any of the above signs								
		4. Checks woman's record for immunization against tetanus and give Injection T.T 0.5 ml if woman is not immunized earlier								
		5. Checks woman's record for ABO Rh status. And if test not done before take sample for Blood grouping.								
		6. Records the information on woman's clinical history								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		sheet								
		7. Assess the gestational age and determine if woman is in premature labour AND if so management of prematurity with antenatal corticosteroids, details below:								
		▪ Assess woman's gestational age								
		▪ Looks for signs and symptoms of labour								
		▪ Give Injection Betamethasone 12 mg IM 2 doses 24 hours apart OR Injection Dexamethasone 6 mg IM 4 doses 12 hours apart								
NLD 3 The provider communicates with the woman and her companion in a cordial manner		1. Greets the woman and her relative(s) in a friendly and culturally accepted manner and offer a seat/chair Introduces her/himself, counterchecking the woman's name and the companion								
		2. Ensures that she/he speaks the language easily understood by the woman								
		3. Explains to the client and her companion what to expect during the visit assuring privacy and confidentiality								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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		throughout her stay in the hospital								
		4. Asks the woman if she wishes her relative to remain during the physical examination/assessment time and acts accordingly								
NLD-4 The provider properly reviews and fills out the clinical history of the woman in labour		1. Asks and records details on the woman's clinical history sheet in a confidential and private environment								
		2. Checks last menstrual period (LMP) and estimated date of delivery (EDD) and calculates gestational age								
		3. Asks about the woman's obstetric history; details below:								
		▪ Number of pregnancies								
		▪ Number of abortions								
		▪ Number of normal deliveries								
		▪ Number of caesarean sections								
		▪ Number of children born alive								
		▪ Number of stillbirths								
		▪ Number of children alive								
		▪ Number of children who died during the first								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		month								
		▪ Number of children who died after first month								
		▪ Date and outcome of the last pregnancy								
		4. Asks the woman about her current labour: details below:								
		▪ When the painful regular contractions began								
		▪ How frequently they are occurring								
		▪ Whether her “bag of waters” broke; if so, when, what colour and smell								
		▪ Whether she feels the baby’s movements								
		▪ Whether she has any doubts or concerns about her labour, and responds using easy-to- understand language								
		▪ Assess about any drug if given								
		▪ History of previous examination or handling in referred cases								
		5. Asks about general medical, surgical history and has history of allergies (foods, drugs or any other.)								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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		6. Asks about use of medications, including natural and herbal remedies during pregnancy and labour								
		7. Asks for signs, symptoms and diagnosis of sexually transmitted infections, HIV and TB; details below								
		▪ Weight loss								
		▪ Night Fever								
		▪ Night sweat								
NLD-5 The provider properly conducts the physical examination		1. Asks the woman to urinate and tests urine for albumin and sugar								
		2. Explains to the woman and her companion what the provider is going to do and encourages her to ask questions								
		3. Ensures privacy during the entire process of the provision of care, at least during examination; details below:								
		▪ Woman remains covered with a sheet								
		▪ Area is separated with curtains, sheets or screens, as appropriate								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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		▪ The minimum number of individuals are present during examinations and birth (the provider attending the birth and a family member—i.e., the individual chosen by the woman preferably female companion)								
		4. Performs hand hygiene - Washes hands with water and soap for 10–15 seconds, paying attention to areas under the fingernails and between the fingers; dries hands with an individual clean towel **or** air dries them or Rubs both hands with approximately 5 ml of alcohol gel 70%, paying attention below to the areas the under the fingernails and between the fingers, until dry								
		5. Takes or delegates taking of vital signs to assistant;								
		▪ Temperature								
		▪ Pulse								
		▪ Blood pressure								
		▪ Respiratory Rate								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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		6. Checks the conjunctiva, nails and palms of hands for anaemia; takes a blood sample, and sends it for haemoglobin test and grouping and cross matching								
		7. Registers findings in the clinical history								
NLD-6 The provider properly conducts the obstetric examination		1. Observes the shape and size of the abdomen and checks for the presence of scars and other skin lesions								
		2. Determines fetal lie and presentation. Avoids examining the woman during a contraction								
		3. Evaluates uterine contractions (frequency and duration over a 10-minute period)								
		4. Auscultates foetal heart rate (FHR)								
		5. Records all findings in the clinical history sheet and partograph								
NLD-7 The provider properly conducts a vaginal examination		1. Explains to the woman in easy-to-understand language what she is going to do and reassures her								
		2. Performs hand hygiene and Puts sterile examination gloves on both hands								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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		3. Sensitively conducts a vaginal examination:								
		a. Cleanses the perineum: ---using the hand that will not be used for the pelvic examination, takes a washcloth or swabs, and cleans the perineum using downward and backward motion								
		b. Soap and water or non-alcohol antiseptic may be used								
		c. Uses the thumb and index finger of the non-exam hand to separate the labia								
		d. Examines the vulva (ulcers, blood, liquid, secretions, presenting part)								
		e. Assesses cervical dilatation and effacement								
		f. Assesses presentation and position of presenting part								
		4. Decontaminate gloved hands, remove gloves inside out and washes hands								

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		5. Covers the woman and explains to her the findings and what they mean								
		6. Records the results of the obstetric examination on the clinical history and partograph								
NLD-8 The provider decides and implements appropriate supportive care during labour, according to the findings of the history and physical examination		1. Encourages presence of companion. Discusses the care decisions with the woman (and her companion, if possible)								
		2. Instructs the woman about the importance of:								
		▪ Going to the toilet often to empty her bladder								
		▪ Taking liquids and light foods whenever she wants								
		▪ Taking deep breaths during contractions								
		▪ Postpartum Family Planning including PPIUCD if woman is in early labour								
		3. In a woman with unknown HIV status determine whether the provider does the following:								
		▪ Discusses with the client about mother-to-child transmission of HIV								

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		▪ Gets consent from the client								
		▪ Performs rapid HIV testing according to national algorithm and provides negative or positive test results								
		▪ Arranges for follow-up counselling, including care and support, disclosure and partner testing, care and follow-up for the baby if mother is HIV positive								
NLD-9 The provider uses the partograph to monitor labour and make adjustments to care		1. Records patient information on partograph; details below:								
		▪ Name								
		▪ Gravida & Parity								
		▪ Hospital number								
		▪ Date and time of admission								
		▪ Time of ruptured membranes								
		2. Information to be recorded every half hour:								
		▪ Foetal heart rate								
		▪ Uterine contractions								
		▪ Maternal pulse rate								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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		▪ Amount of IV solution with Oxytocin in drops/minute if the woman was commenced on Oxytocin or any other drug /fluids provided								
		▪ Records the condition of the membranes and characteristics of the amniotic fluid								
		3. Information to be recorded every four hours:								
		▪ Per vaginal examination with Cervical Dilatation								
		▪ Blood pressure								
		▪ Temperature								
		4. Records the time of the above observations								
		5. Adjusts care according to the parameters encountered:								
		▪ If parameters are normal, continues care as planned (walk about freely, hydration, light food if desired, change positions, etc.) **OR** If parameters are not normal, identifies complications, records the diagnosis and makes								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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		adjustments to care								
NLD-10 The provider prepares to assist the birth		Observe TWO women in labour and determine whether the provider (in the labour or delivery rooms) has prepared the following:								
		1. Provider ensures availability of a sterile delivery sets and other essential materials including linens for woman								
		2. Allows the woman to give birth in the position she wants/desires and in the same bed where she has laboured (if possible)								
		3. Ensures privacy of the woman								
		4. Encourages the woman to empty her bladder								
		5. Explains to the woman how to support herself and manage the bearing down process (when and how)								
		6. Encourages and speaks kindly to the woman during labour								
NLD-11 The provider assists the woman to have a safe and clean		1. Monitors, or has assistant monitor, foetal heart rate every 5 minutes during second stage								
		2. Puts on personal protective								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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birth		equipment								
		3. Washes hands with soap and water and dries them, or applies alcohol rub and puts on two pairs of sterile gloves								
		4. Cleanses the perineum with water or a non-alcoholic antiseptic solution								
		5. Allows the woman to bear down when she feels the desire (not forcing her to bear down)								
		6. Performs an episiotomy only if necessary (breech, shoulder dystocia, forceps, vacuum, poorly healed 3rdor 4thdegree tear, over stretched perineum or foetal distress)								
		7. Allows the head to spontaneously crown while guarding the perineum								
		8. After the emergence of the head, asks the woman to briefly refrain from bearing down (open mouth breathing)								
		9. Assists in delivering the baby:								
		▪ Quickly palpates to determine cord around the neck; if it is loose, slides it over the baby's								

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		head; if it is very tight, clamps it in two places and cuts it before unravelling it from around the baby's neck								
		▪ Allows spontaneous external rotation of the head without manipulation								
		▪ Carefully takes the baby's head in both hands and applies gentle downward traction until the anterior shoulder has emerged (no neck holding)								
		▪ Guides the baby's head and chest upward until the posterior shoulder has emerged								
		▪ Holds the baby by the trunk and places it on a dry towel/cloth on the mother's abdomen								
NLD 12 The provider properly conducts a rapid initial assessment and provides immediate newborn care		In the labor or delivery rooms, observe two women with their newborns in the immediate postpartum period and determine whether the provider:								
		1. Receives and dries the baby with a clean dry towel from head to feet, discards the used towel and covers the baby including the head with								

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Note 1: This standard must be observed immediately following birth Note 2: It may be necessary to have two providers and observers in the event that one provider is caring for the woman and the other for the newborn		a clean dry towel								
		2. Determines whether the baby is breathing								
		3. If the baby does not begin breathing or is breathing with difficulty, asks assistance, rapidly ties and cuts the cord, and initiates resuscitation- see NLD-13								
		4. Palpate abdomen to rule out presence of other baby and gives IM oxytocin at this stage,								
		5. If the baby is breathing normally, places the baby in skin-to-skin contact on the mother's chest or abdomen and encourages "Baby Crawl" practice and immediate breastfeeding								
		6. Informs the attendant of the baby's condition								
		7. Clamps and cuts the cord using clean sterile blade/instruments within 1-3 minutes of the birth								
		8. Cleans the baby's eyes with separate sterile gauze/ cotton balls from medial to lateral side								

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		9. Places an identification bracelet on the baby's wrist								
		10. If necessary, provides orientation to the mother about how to hold her baby and encourages breastfeeding								
NLD-13 The provider properly performs resuscitation of the newborn		1. Determine whether the provider:								
		▪ Places the newborn face up on a clean, dry, hard surface under a heat source or warmer(ensures warmer is on at least half an hour before baby's birth)								
		▪ Quickly wraps and covers the baby, except for the face and the upper portion of the chest								
		▪ Explains to the attendant what is happening								
		▪ Positions the head of the baby so that the neck is slightly extended which may be achieved by placing a rolled up piece of cloth (shoulder roll) under the baby's shoulders								
		▪ Gently sucks the baby's mouth and then nose if								

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		meconium is present and the baby is not crying (does not suck deep in the throat which may cause bradycardia)								
		▪ After performing the above steps of resuscitation, if the baby does not breathe initiates bag and mark ventilation								
		2. In the event of resuscitation with bag and mask:								
		▪ Places the mask so it covers the baby's chin, mouth and nose								
		▪ Ensures that an appropriate seal has been formed between mask, nose, mouth, and chin								
		▪ Ventilates one or two times and looks for chest movement during ventilation (chest is rising equally on both sides)								
		▪ If no chest movement, check for inadequate seal or blocked airway or insufficient pressure								
		▪ Ventilates for 30 secs at the rate of 40-60 breathes/minute								

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		▪ If breathing well, gradually discontinues positive pressure ventilation, check breathing for one minute and keep the baby under observation								
		▪ If not breathing well, continue ventilation, assess the heart rate and add oxygen if available								
		▪ If heart rate is more than 100/min continue ventilation and assess for breathing after 30 secs								
		▪ If heart rate is less than 100/min, continue ventilation and call for help								
		▪ Encourages the importance of crucial 1 minute (GOLDEN MINUTE) after birth for the baby to start breathing								
		3. If the baby is breathing and there is no sign of respiratory difficulty (intercostal retractions or grunting):								
		▪ Places the wrapped baby in skin-to-skin contact with the mother								
		▪ Ensures that the baby continues to breathe								

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		without difficulty and is kept warmly covered								
		4. If the baby does not begin to breathe or if breathing is less than 20/min or gasping,								
		▪ Continues to ventilate								
		▪ Administers oxygen, if available								
		▪ Assesses the need for special care								
		▪ Explains to the mother what is happening if possible								
		5. If there is no breathing after 20 minutes of ventilation or gasping type of breathing for 30 minutes								
		▪ Suspends Resuscitation								
		▪ Records the time of death (no breathing)								
		▪ Records the time of death (no breathing)								
		6. Record all actions taken on the woman's clinical record								
		7. Asks the mother whether she has any questions, and responds using easy-to-understand language								

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		8. Care after successful resuscitation								
		▪ Keeps the baby skin-to-skin with the mother until the baby's condition is stable								
		▪ Monitors the baby's respiratory rate and observe for other signs of illness								
		▪ Provides reassurance to the mother								
		▪ Washes hands thoroughly after removing the gloves								
		▪ Completes records with details of resuscitation and condition of newborn								
NLD-14 The provider adequately performs active management of the third stage of labour		1. Palpates the mother's abdomen to rule out the presence of a second baby (without stimulating contractions)								
		2. Tells the woman that she will receive an injection of oxytocin								
		3. Administers 10 IU of oxytocin IM within 1 minute of birth								
		4. Performs controlled cord traction:								
		▪ Re-clamp the cord near the perineum								

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		▪ Hold the cord and clamps with one hand								
		▪ Place the other hand on the woman's symphysis pubis (over the drape) and gently push upward in the direction of her abdomen								
		▪ Maintain firm traction on the cord and wait for the uterus to contract								
		▪ Upon contraction, apply firm and sustained downward traction on the cord with counter force above the pubis to guard the uterus, until the placenta is expelled								
		▪ If this manoeuvre does not provide immediate results, cease to apply traction, holding the cord and clamp until the next contraction								
		▪ Repeat controlled cord traction while simultaneously applying counter pressure above pubis to guard uterus								
		▪ With both hands, assist in the expulsion of the placenta, by turning it over in the hands, without applying traction, "teasing								

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		out" the membranes								
		5. After expulsion of the placenta, massages the uterus with one hand over the abdomen, until the uterus contracts firmly								
		6. Examines the placenta and membranes to check if complete								
		7. Measures blood loss; if the woman's condition is affected by the blood loss, decides immediate action								
NLD-15 The provider adequately performs immediate postpartum care		1. Informs the woman what she is going to do before proceeding, then carefully examines the vagina and perineum								
		2. Gently cleanses the vulva and perineum with clean water or a non-alcoholic antiseptic solution								
		3. Sutures tears/episiotomy/ lacerations if necessary								
		4. Checks if the uterus is well contracted; if not, massages fundus,								
		5. Checks for excessive bleeding and if it is there prepares for the management								

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		6. Covers the perineum with a clean sanitary pad								
		7. Makes sure the woman is comfortable (clean, hydrated and warmly covered)								
		8. Before shifting out baby and mother from labour room ensures the baby is well covered, is with the mother and has begun to suckle within an hour of birth								
		9. Registers findings and events in clinical record								
NLD-16 The provider properly disposes off the used instruments and medical waste after assisting the birth		1. Puts on gloves while disposing off used instruments and medical waste								
		2. Discards the placenta and medical wastes in a leak-proof container with a yellow plastic liner								
		3. Puts the soiled linen in a leak-proof container								
		4. Opens (un-hinges) all instruments and immerses them in a 0.5% chlorine solution for 10 minutes								
		5. Disposes of the needle in hub cutter and syringe in a container with red plastic bag (for rubber/plastic materials)								

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		6. Wipes down all surfaces with 0.5% chlorine solution								
		7. Rinse gloved hands in 0.5% chlorine solution then removes gloves by turning inside out and places them in a container with a red plastic liner and Performs hand hygiene after removing gloves								
NLD-17 The provider properly monitors the newborn in immediate postpartum period		1. Checks that the baby is warm by touching baby's chest								
		2. If cold, follows procedure for warming the baby up:								
		▪ Verify body temperature by checking axillary temperature								
		▪ Make sure the baby is kept warm by maintaining skin-to-skin contact								
		▪ If skin-to-skin contact is not possible, re-wrap the baby, including the head, and place the baby under a heat source or in incubator								
		▪ Continue to monitor temperature on an hourly basis or until temperature stabilizes								
		3. Continues to observe baby for any problems								

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		4. Checks and records the baby's weight								
		5. Counter checks bleeding from the cord								
		6. Ensures name tag has been put on to the baby's wrist with mother's number or name written down								
		7. Put on cap and socks to maintain warmth								
		8. Administer Injection vitamin K 1.0 mg, intra muscular to all newborns weighing 1500 gms and above and in a dose of 0.5 mg to newborns weighing less than 1500 gm.								
NLD-18 The provider closely monitors the woman for at least two hours after the birth		1. Keeps the woman in the delivery or postnatal ward to be monitored for at least two hours after the birth, checking the woman's vital signs, bleeding and ensuring both mother and baby are comfortable								
		2. Monitors specific indicators in the woman every 15 minutes in the first hour:								
		▪ Uterine tone								
		▪ Vaginal bleeding								
		▪ Bladder distension								

Area 1: Normal Labour and Delivery including Immediate Newborn Care										
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		▪ Pulse rate								
		3. Monitors specific indicators in the woman every 30 minutes in the second hour:								
		▪ Uterine tone								
		▪ Vaginal bleeding								
		▪ Bladder distension								
		▪ Blood pressure								
		▪ Pulse rate								
		4. Asks the woman if she has passed urine within the two hours after delivery and encourages her to do so whenever she wishes								
		5. Records the information on the woman's clinical record								

Total standards in NLD	18	18	18	18
Total standards observed				
Total standards met				
Percentage/ Score				

Integrated Performance Standards for Maternal and New born Care

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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MCLD-1 **The provider properly performs the general management and follow up of primary and secondary PPH** **(This standard is based on review of notes however where possible try to observe the actual management of a patient AND check the records)**		Review the records of two women who had PPH, determine whether the records include the following or interview the provider in the clinical area whether the following is done in the event of PPH:								
		1. Rapid evaluation: (General condition, Pulse, BP, Breathing)								
		2. If there is shock or suspicion of shock [weak, fast pulse (110 or more per minute), systolic BP less than 90 mmHg, pallor, cold and perspiring skin, rapid breathing, confusion or unconsciousness]:								
		▪ Woman is covered and has her feet elevated above the level of her heart								
		▪ Starts oxygen at 6–8 L/minute by mask								
		▪ Starts two IV lines using wide bore needle/canula with saline or Ringer Lactate or Plasma expanders, 1 Ltr in each line over 15-20 mins								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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		▪ Takes a blood sample for hemoglobin, cross-matching,, clotting test and arrange for blood if required								
		▪ Arrange for referral transport if blood transfusion facility is not available								
		▪ Administers at least 2 additional liters of solution during the first hour if required as per the blood loss								
		▪ Continues to replace volume IV according to blood loss and measures in take every hours								
		▪ Assesses woman's need for transfusion based upon signs and symptoms of shock or impending shock due to amount of blood lost								
		▪ Performs bladder catheterization and measures for urine output every hour								
		▪ Administers 20 IU of oxytocin in 500 ml Normal Saline or R/L at 40-60 drops per minute.								

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		Performs Bimanual compression of the uterus								
		3. If inspite of above actions uterus remains relaxed **Add** other line of uterotonics like Misoprostol/Injection Ergometrine/ Injection Prostodin								
		4. Monitors uterine contractions, vital signs and bleeding every 15 minutes during first 2 hours then every 30 minutes for 4 hours								
		5. Mesaures haematocrit and haemaoglobin 24 hours after haemorrhage has been controlled and manages accordingly								
		6. Records information in patient's records								
		7. If there is infection, gives prescribed broad spectrum antibiotics like Ampicillin 1g IV for 48 hours, then 500mg QID for five days, Metronidazole 500mg IV for 48 hours, then 400mg orally for five days and gentamycin 80mg IM 12 hourly for five days								
		8. Check Hb to rule out anaemia; if haemoglobin								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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		level is less than 8.5g/dl give IFA orally for one month then review; if haemoglobin level is less than 5g/dl transfuse with whole blood ** (Role of tablet Iron/ Injectable Iron/ Blood transfusion-whole or packed cells will be as per GOI guidelines)								
MCLD-02 The provider properly performs the specific management of the cause of the PPH		1. Identifies the cause of bleeding and initiates specific management immediately (verified by observation, , interview or clinical records)								
		2. Manages bleeding using the appropriate procedure if bleeding is due to retained placenta or placental fragments :								
		▪ Administer another dose of oxytocin 20 IU in 500 ml of R/L at 40-60 drops/ min and attempt to deliver placenta with repeat controlled cord traction (with counter traction on uterus)								
		▪ If this maneuver fails, performs manual removal of placenta and In the event of manual removal of placenta, administer single dose of ampicillin 2								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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		g IV PLUS metronidazole 500 mg IV (8 hrly for 48 hrs) and Gentamycin injection 80mg BD IV								
		3. Manages bleeding using the appropriate procedure if bleeding is due to uterine atony: Explain to the woman what you are going to do, then								
		▪ Perform vigorous uterine massage								
		▪ Administer oxytocin 20 IU in 500 ml of R/L, 40-60 drops/minute								
		▪ Continue to administer oxytocin 20 IU in 500 ml of R/L, 40 drops/minute, up to a maximum of 3 litres of solution with oxytocin, if necessary,								
		▪ If bleeding continues, perform bi-manual uterine compression								
		▪ If bi-manual compression fails, apply abdominal aorta compression with palpation of femoral pulse or perform other appropriate procedures								
		4. Manages bleeding using the appropriate procedure if								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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		bleeding is due to perineal or cervical tears:								
		▪ Explain the problem and tell the woman what you are going to do								
		▪ Immediately suture the tears using Lidocaine injection first								
MCLD-3 **The provider correctly manages and follows up severe pre-eclampsia and/or eclampsia (if a case is not observed check patient records/ interview)**		1. There is a record or interview with basic information that supports the diagnosis of severe pre-eclampsia and/or eclampsia:								
		FOR PRE-ECLAMPSIA: ▪ BP >160/110 mmHg or more ▪ 20 weeks or more of gestation ▪ Proteinuria 3+ or more								
		FOR ECLAMPSIA: ▪ Convulsions ▪ Diastolic BP 90 mmHg or more ▪ 20 weeks or more of gestation ▪ Proteinuria 2+ or more								
		2. Documentation of **Initial Dose** of Magnesium Sulfate:								
		▪ Administers 4 g of 20% magnesium sulfate in								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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		solution (20 ml) IV over a 20-minute period								
		▪ Administers 5 g of 50% magnesium sulfate solution (20 ml) with 1 ml of 2% lidocaine IM deep in each buttock (total 10 g)								
		▪ In the event of a second convulsion after 15 minutes, administers 2 g of 20% magnesium sulfate in solution (4 ml) IV over a 20-minute period								
		3. If BP is 140/90 mmHg or more with proteinuria 2+ along with danger signs like severe headache, blurring of vision, severe pain abdomen or reduced urine output OR BP shoots to 160/110 or more with proteinuria 3+, or in cases of eclampsia there is a record that magnesium sulfate treatment was initiated immediately								
		4. IV line was started with saline or Ringer's lactate solution								
		5. If BP is >160/110 mmHg or more, **anti-hypertensive** was given : Antihypertensive treatment (if diastolic BP is 110 mmHg or more):								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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		▪ Plan 1: Hydralazine 5 mg IV slowly over 3-4 minutes; repeat at 30 minute intervals (DO NOT give more than 20mg in total) or 12.5 mg IM every 2 hours, until diastolic BP stabilizes between 90 and 100 mmHg **OR**								
		▪ Plan 2: Nifedipine 5 mg sublingual, repeating the dose if the diastolic BP is still more than 110 after 10 minutes ** (as per GOI guidelines) **OR**								
		▪ Plan 3: Injection Labetalol								
		6. Correctly administers the **maintenance dose** of magnesium sulfate: Prior to administration of the maintenance dose records show:								
		▪ Respiration more than 16/minute								
		▪ Patellar reflexes are present								
		▪ Urine output more than 30 ml/hour								
		▪ Administers 5 g of 50%								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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		magnesium sulfate solution with 1 ml of 2% lidocaine IM alternately in each buttock every 4 hours, providing there are no complications								
		▪ Continues with magnesium sulfate for 24 hours following birth or the most recent convulsion								
		7. Simultaneously, there is record of:								
		▪ Bladder catheterization								
		▪ Intake and output monitoring every shift								
		▪ Monitoring of vital signs (i.e., BP, pulse, breathing)Monitoring of fetal heart rate								
		▪ Performance and evaluation of clotting tests								
		▪ If there were convulsions, birth took place within 12 hours following the convulsion or, in the absence of convulsions, within 24 hours								
		8. Hourly monitoring of toxicity is documented in patient record until the patient								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		improves:								
		▪ Patellar reflexes								
		▪ Urinary output								
		▪ Signs and symptoms of pulmonary oedema								
		▪ Respiratory rate								
		9. If respirations are less than 16/minute, patellar reflexes absent, or urinary output is less than 30 ml/hour, **suspension or postponement** of the use of magnesium sulfate is documented								
		10. If urine output is less than 30 ml/hour, magnesium sulfate is **withheld** and patient infused with 1 litre IV fluids over eight hours, with monitoring for pulmonary oedema								
		11. In the event of respiratory arrest, appropriate procedures were performed:								
		▪ Perform assisted ventilation								
		▪ Administer calcium gluconate 1 g (10 ml of a 10% solution) IV slowly								
		12. If there was pulmonary oedema, a single dose of furosemide 40mg IV was								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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		administered								
MCLD 4: **The provider correctly manages obstructed labour**		1. Diagnoses obstructed labour based on data registered from the partograph showing prolonged labour:								
		▪ No advance of the presenting part despite strong uterine contractions								
		▪ Fetal distress								
		▪ Maternal distress								
		▪ Bandl's ring								
		▪ Third degree molding/caput								
		Presenting part not applied to cervix								
		▪ Dehydration								
		▪ Temperature								
		2. Re-hydrates the patient to maintain normal plasma volume, and prevents or treats dehydration and ketosis								
		3. Checks and records vital signs								
		4. Gives broad spectrum antibiotics to prevent puerperal sepsis								
		5. Takes blood for Hb, grouping								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		and X-matching								
		6. Performs bladder catheterization								
		7. Decides on the mode of delivery: If the baby was alive, the baby was delivered immediately to avoid trauma to mother and baby								
		▪ If rupture of the uterus was suspected, resolved by caesarian section								
		▪ If the uterus was intact, presentation was vertex, the cervix was fully dilated, foetus at term and the descent was 0/5, delivered the baby by vacuum extraction								
		▪ If descent was 1/5 or 2/5, a doctor performed vacuum extraction in theatre								
		▪ If descent was 3/5 and cervix was fully dilated, the mode of delivery was caesarian section								
		▪ If the baby was dead and the uterus was ruptured, the mode of delivery was laparatomy								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		▪ If the baby was dead and uterus was intact with cephalic presentation, cervix fully dilated and head descent 2/5 or more, craniotomy or destructive operation was the mode of delivery								
MCLD-5 The provider correctly follows up resolved obstructed		1. Ensures indwelling Foley urethral Catheter for 7 to 14 days								
		2. Administers broad spectrum antibiotics for 7 days								
		3. Rules out vesico-vaginal fistula or recto-vaginal fistula								
		4. Informs mother and significant others on the cause of her condition								
		5. Provides emotional support and care for newborn								
MCLD-6 The provider correctly manages prolonged second stage of labour		Review a case record or interview a provider to verify that the prerequisites for performing a vacuum delivery are met:								
		1. The presentation is vertex								
		2. The foetus is at term								
		3. The cervix is fully dilated								
		4. Foetal head at least at 0 station or at the level of ishchial spines								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
MCLD-7 The provider correctly manages puerperal sepsis		1. Diagnoses puerperal sepsis based on clinical criteria								
		▪ Continuous fever during at least 24 hours or recurring within the first 10 days after delivery								
		▪ Increased pulse rate								
		▪ Increased respiration								
		▪ Offensive lochia								
		▪ Subinvolution of the uterus								
		▪ Headache and general malaise								
		▪ Pelvic pain								
		▪ Pain, swelling and pus discharge from laceration or episiotomy or incision								
		2. Orders laboratory investigations, including full blood count, high vaginal swab, Blood slide for MPs and urinalysis								
		3. Prescribes general care measures: isolation, client in bed but in upright position								
		4. Monitors vital signs and fluid balance								
		5. Checks uterus for involution								

Area 2: Management of Antenatal, Intrapartum and Postpartum Complications										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		6. Prescribes IV fluids and broad spectrum antibiotics for seven days								
		7. Provides perineal care								

Total standards in MCLD	7	7	7	7
Total standards observed				
Total standards met				
Percentage/ Score				

Integrated Performance Standards for Maternal and New born Care

Area 3: Postnatal care for the woman and the neonate

Area 3: Postnatal care for the woman and the neonate										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
PNC-1 The provider treats the woman in a cordial and culturally accepted manner		1. Greets the woman and her companion in a respectful and cordial manner								
		2. Introduces her/himself and counterchecks the woman's name								
		3. Speaks using easy-to-understand language for the client								
		4. Encourages the woman and her companion/husband to ask questions and responds to them effectively								
		5. Explains to the woman what is going to be done and encourages them to ask questions								
PNC-2 The provider verifies the existence of clinical record for the woman		1. Reviews the woman's clinical history								
		2. If clinical history not complete, asks the woman and completes all information required:								
		▪ General health								
		▪ Obstetric history								
		▪ Date and time of delivery								
		▪ Type of delivery								
		▪ Where and who delivered the baby?								

Area 3: Postnatal care for the woman and the neonate										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		▪ Any complications at delivery or since?								
		▪ Baby – gestation; weight; condition, any problems?								
		3. Asks the woman or her companion about any signs of depression, insomnia, lack of appetite or preoccupations she may have								
PNC-03 The provider conducts routine physical examination of the woman		1. Checks and looks for the minimum required equipment and supplies for providing postnatal care								
		▪ Sterile /Examination gloves								
		▪ Blood pressure equipment								
		▪ Thermometer- Adult and neonatal								
		▪ Tape measure								
		▪ Weighing scale								
		▪ Sanitary pads								
		▪ Alcohol Hand rub/soap and water								
		▪ Stationary								
		▪ Examination table/bed								
		▪ IP equipment (bucket 0.5% chlorine, waste container with leak-proof								

Area 3: Postnatal care for the woman and the neonate										
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			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		plastic bag, and safety box)								
		▪ Torch								
		▪ Clock								
		2. Washes hands with soap and water and dries them or uses alcohol hand rub								
		3. Assures privacy with good ventilation and light								
		4. Assesses general condition, including the - weight of the client, vital signs, conjunctiva for pallor and jaundice, and bladder and bowel function								
		5. Examines breasts for engorgement, tenderness, cracked/sore and inverted nipples								
		6. Gives advice for exclusive breastfeeding for six months or for any breast problem encountered								
		7. Palpates the abdomen for involution of uterus, tenderness and distension								
		8. Washes hands and wears sterile/examination gloves on both hands before conducting perineum examination, if needed								
		9. Examines the perineum for								

Area 3: Postnatal care for the woman and the neonate										
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		inflammation, status of episiotomy/tears, lochia for colour, amount, consistency and odour								
		10. Checks calf tenderness, redness or swelling								
		11. Records findings in the client chart								
PNC-4 The provider educates and counsels the mother about proper care during the puerperium		1. Advises the mother to report to the health facility when any danger sign is observed during the puerperium in mother and baby. Gives date for her next routine postpartum visit, preferably within seven days, insisting she comes even if there is no danger sign								
		DANGER SIGNS FOR MOTHER: ▪ Excessive PV bleeding ▪ Convulsions ▪ Breathing difficulties ▪ Severe headache ▪ Severe abdominal pains ▪ Foul smelling lochia ▪ Fever ▪ Palpitations/excessive tiredness ▪ Urine dribbling or pain on micturition ▪ Perineal pain or draining pus ▪ Painful or redness in breasts								

Area 3: Postnatal care for the woman and the neonate										
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		2. Advises the mother on healthy dietary practices:								
		▪ Nutrition (animal proteins, legumes, green vegetables, fats, carbohydrates, fruits and vitamins)								
		▪ Importance of taking regular meals containing mixed foods								
		▪ Importance of taking enough fluids, 2–3 litres of water								
		▪ Exclusive breastfeeding and other infant feeding options where appropriate								
		3. Advises the mother on personal and environmental hygiene								
		▪ Availability of luke warm water for perineal care (wiping from front to back, sitz bath, changing pads)								
		▪ Adequate rest and sleep								
		▪ Kegel exercises								
		4. Advises the mother on HIV and malaria prevention								
		▪ Importance of knowing one's HIV status to prevent mother-to-child								

Area 3: Postnatal care for the woman and the neonate										
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		transmission								
		▪ Prevention, testing and management of HIV and AIDS								
		▪ Prevention of malaria (use of insecticide-treated nets)								
		5. Counsels the partner and other family members on psycho-social support of the mother								
		▪ Need for assistance with home task								
		▪ Need for postnatal and under-five visits								
		▪ Family planning								
		▪ Testing on HIV/AIDS								
		▪ Resumption of sexual activity								
		▪ Timely use of health facility in case of any complications								
		▪ Immunizations								
		▪ Nutrition								
		6. Gives analgesics, vitamin A,IFA , calcium and other prescribed medicines								
PNC-5 The provider is able to counsel clients		Observe providers counseling clients or interview staff regarding how they provide this								

Area 3: Postnatal care for the woman and the neonate										
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regarding postpartum contraception and Lactational Amenorrhoea Method (LAM)		specific type of counseling to verify the following:								
		1. Promotes exclusive breastfeeding explaining the 3 LAM criteria and counsel on the contraceptive methods that are compatible with breastfeeding i.e. postpartum Family Planning methods including PPIUCD								
		2. Knowledge of the difference between breastfeeding women and women who use LAM as their method of family planning								
		3. Benefits of healthy timing and spacing of pregnancy								
		4. Explains the fertility can return as early as 4 weeks after delivery if woman is not following LAM								
PNC-6: The provider properly assesses condition of the neonate		1. Prepares the minimum equipment and supplies for the subsequent care of the neonate								
		▪ Examination gloves								
		▪ Measuring tape								
		▪ Weighing scales								
		▪ Thermometer								
		2. Washes and dries hands and wears examination gloves:								

Area 3: Postnatal care for the woman and the neonate										
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		▪ Washes their hands with water and soap for 10–15 seconds, paying attention to areas under the finger nails and between the fingers; dries hands with an individual clean towel or air dries them OR								
		▪ Rubs both hands with approximately 5 ml of alcohol hand rub 70%, paying attention below to the areas the under the finger nails and between the fingers, until dry								
		3. Keeps the baby warm (proper wrapping)								
		4. Checks weight								
		5. Checks temperature, respiration and heart rate every 15 minutes for first hour and then every 30 minutes for next second hour								
		6. Assesses the neonate from head to toe to exclude abnormalities								
		▪ General appearance								
		▪ Head, face, neck and								

Area 3: Postnatal care for the woman and the neonate										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		eyes								
		▪ Oral cavity								
		▪ Hands and fingers								
		▪ Chest, abdomen and umbilical cord								
		▪ External genitalia, including anal opening								
		▪ Back and spine								
		7. Checks and discusses with the mother on breastfeeding pattern, emphasizing exclusive and demand feeding								
PNC-7 The provider properly manages the neonate The provider counsels the mother on baby care		1. Gives immunization (BCG, Polio 0, Hepatitis B 0)								
		2. Gives ARV prophylaxis syrup where necessary								
		3. Demonstrates the proper positioning and attachment of the baby on the breast								
		4. In the event of danger sign/illness or serious abnormality, refers to special clinic with proper referral note								
		5. Records all findings in baby case sheet								
		6. Advises the mother to bring the baby to the health facility immediately when she sees								

Area 3: Postnatal care for the woman and the neonate										
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		any danger signs of the baby as follows								
		▪ Poor suckling/feeding								
		▪ Persistent/abnormal crying								
		▪ Lethargy								
		▪ Purulent eye or cord discharge								
		▪ Yellow discoloration of eyes, skin or mucous membranes								
		▪ Failure to pass stool or urine								
		▪ Skin pustules								
		▪ Breathing difficulties								
		▪ Not feeding at all								
		▪ Bleeding								
		▪ Convulsions								
		▪ Diarrhoea								
		▪ Fever or feels cold								
		7. Counsels on the importance of keeping the baby warm, proper positioning of the baby to avoid suffocating, and keeping the baby in a safe environment								
		8. Advises on the importance of preventing diseases: completion of immunization,								

Area 3: Postnatal care for the woman and the neonate										
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		protecting the baby from infection through hand washing and personal hygiene, appropriate care of the cord and baby bathing/skin hygiene ** (Avoid giving bath for first 24 hours)								
		9. Promotes immediate and exclusive breastfeeding, demonstrates positioning and attachment of the baby to the breast; if breastfeeding would not be advisable, gives alternative feeding options								
		10. Advises the mother to combine her postpartum visits together with the baby								
		11. Records findings in the baby case sheet								
PNC-8 All low birth weight (LBW) and premature babies are recorded and followed up according to their condition		Check delivery register to verify that:								
		1. Premature and LBW babies are recorded in delivery register:								
		▪ Weight less than 2500 g for low birth weight babies								
		▪ gestation of Less than 37 weeks for prematurity								

Area 3: Postnatal care for the woman and the neonate										
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		2. Kangaroo Mother Care (KMC) is implemented for LBW/prematurity								
		3. Assisted feeding, if required								

Total standards in PNC	8	8	8	8
Total standards observed				
Total standards met				
Percentage/ Score				

Integrated Performance Standards for Maternal and New born Care

Area 4: Infrastructure and Human Resources

Area 4: Infrastructure and Human Resources										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
IHR -1 The place and furniture in the labour room are consistent with the Government of India, SBA guidelines		Observe whether the following are present at the site:								
		▪ Examination table/bed								
		▪ Privacy maintained—curtains/screen								
		▪ Adequate light to visualize cervix								
		▪ Electricity supply with back-up facility (generator with POL)								
		▪ Attached toilet facilities								
		▪ Delivery table with mattress and Macintosh and Kelly pad								
		▪ Foot stool & bedside table								
		▪ Basin stand								
		▪ Area marked for care and resuscitation of newborn								
		▪ 1 table and 3 chairs in the side room of the labour room								
		▪ Protocol charts/posters for infection prevention, intrapartum care, complications management ** (SBA Posters-16, posters for facilities by GOI)								
IHR-2 Infection prevention equipment is		Observe whether the following are present at the site:								
		▪ 10 litre bucket with tap or running water (24 hrs								

Area 4: Infrastructure and Human Resources										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
available as required based on the Government of India, SBA guidelines		▪ Plain plastic tub for labour room is 2*1.5*1.5 feet for 0.5% chlorine solution								
		▪ Hypochlorite solution/bleaching powder in air tight container								
		▪ Autoclave/boiler / pressure cooker								
		▪ Stove in working condition (used for boiling)								
		▪ Plastic mug (1 litre)								
		▪ Teaspoon/measurement jar for measuring bleaching powder								
		▪ Surgical gloves (No. 6.5/7)								
		▪ Utility gloves (thick rubber)								
		▪ Soap in a soap dish with holes/liquid soap in a dispenser								
		▪ Puncture-proof container/hub cutter and needle destroyer								
		▪ Personal Protective equipment including plastic apron, shoes or shoe covers, mask, cap, goggles								
		▪ Dustbin—colour-coded, based on state biomedical waste management guidelines								

Area 4: Infrastructure and Human Resources										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
IHR-3 Emergency drug tray is available as required based on the Government of India, SBA guidelines		Observe whether the following are present at the site:								
		▪ Injection oxytocin								
		▪ Injection diazepam								
		▪ Tablet Nifedipine								
		▪ Injection magnesium sulphate								
		▪ Injection lignocaine hydrochloride								
		▪ Tablet misoprostol								
		▪ Sterilized cotton and gauze								
		▪ At least 2 pairs of gloves								
		▪ Sterile syringes and needles (different sizes)								
		▪ At least 2 sterile intravenous sets								
		▪ Intravenous fluids								
		▪ Intravenous cannula								
		▪ Inj. Calcium Gluconate								
		▪ Dopamine								
		▪ Adrenaline								
		▪ Injection Vitamin K								
		▪ Sodium bicarbonate								
		▪ Injection Hydrocortisone								
		▪ Injection Hydralazine								
		▪ Injection Labetalol								

Area 4: Infrastructure and Human Resources										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
IHR-4 Equipment, supplies and other drugs are available as required based on the Government of India, SBA guidelines		Observe whether the following are present at the site:								
		▪ Foetal Doppler								
		▪ Dressing Trolley								
		▪ Delivery kits for normal deliveries								
		▪ Cheatle forceps in a sterile/HLD dry bottle								
		▪ Dressing drum								
		▪ Foetal stethoscope								
		▪ Baby weighing scale								
		▪ Inch tape								
		▪ Radiant warmer								
		▪ Table lamp with 200 watt bulb								
		▪ Phototherapy unit								
		▪ Self-inflating bag and mask (neonatal size 0 and 1)								
		▪ Oxygen hood (neonatal)								
		▪ Oxygen cylinder or central supply with Key tubing and mask /Oxygen Concentrator								
		▪ Laryngoscope and endotracheal tubes								
		▪ Mucus extractor with suction tube and foot-operated suction machine								
		▪ Feeding tubes								

Area 4: Infrastructure and Human Resources										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		▪ Blankets, Clean towels								
		▪ Sahle haemoglobinometer								
		▪ Dipsticks for testing urine albumin & sugar								
		▪ Blood pressure apparatus and stethoscope								
		▪ Adult weighing scale								
		▪ Sterile/clean pads								
		▪ Bleaching powder in air tight container								
		▪ Povidone iodine								
		▪ Methylated spirit								
		▪ Thermometer (oral & rectal)								
		▪ Micropore tape								
		▪ MCH card								
		▪ Partograph charts								
		▪ Gentamicin injection								
		▪ Ampicillin injection								
		▪ Metronidazole Tablets								
		▪ Vaccine carrier								
		▪ Ice pack box / refrigerator								
		▪ Foley and plain catheters and uro bag								
		▪ Newborn mask size 1								
IHR-5 The in-patient		1. The area is well ventilated (open windows,)								

Area 4: Infrastructure and Human Resources										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
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maternity ward is adequate for providing postnatal care		2. The area is well illuminated								
		3. There is only one woman in each bed								
		4. There are chairs for mothers								
		5. Mothers have easy access to bathrooms and toilets (in or near the area)								
IHR-6 Bathrooms and toilets in the labour, delivery and postpartum areas and for personnel on duty are adequate The area for personnel on duty is satisfactory		Verify that the bathrooms toilets have:								
		▪ A door that can be locked from inside								
		▪ A working washbasin with water tap								
		▪ Soap								
		▪ supply of luke warm water for perineal cleansing								
		▪ Covered container with red plastic liner for waste								
		▪ Working toilet with tank/flush								
		▪ Water tap								
		▪ The area for personnel on duty is well ventilated (open windows) and well illuminated								
		▪ Place to store clothing and personal effects securely								
		▪ Area is having telephone and sufficient beds for the number of duty personnel or								

Area 4: Infrastructure and Human Resources										
STANDARD	SCORE	VERIFICATION CRITERIA	Date		Date		Date		Date	
			YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO – N Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks	YES - Y, NO - N, Not applicable - NA	Remarks
		on call								
IHR-7 Manpower in SDH or RH/CHC are as per IPHS revised 2012 guidelines **		Manpower including medical, paramedical, administrative and grade 4 staffs are as per IPHS guidelines for SDH and CHC/RH								

Total standards in IHR	7	7	7	7
Total standards observed				
Total standards met				
Percentage/ Score				