# HAND WASHING

## STEPS OF HAND WASHING

<table>
<thead>
<tr>
<th>TECHNIQUE</th>
<th>MAIN PURPOSE</th>
<th>AGENTS</th>
<th>RESIDUAL EFFECT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine hand washing</strong></td>
<td>Cleansing</td>
<td>Non medicated soap</td>
<td>Short</td>
</tr>
<tr>
<td><strong>Careful hand washing</strong></td>
<td>Cleansing after patient contact</td>
<td>Non medicated soap</td>
<td>Short</td>
</tr>
<tr>
<td><strong>Hygienic hand rub</strong></td>
<td>Disinfection after contamination</td>
<td>Alcohol</td>
<td>Short</td>
</tr>
<tr>
<td><strong>Surgical hand disinfection</strong></td>
<td>Pre-operative disinfection</td>
<td>Antibacterial soap</td>
<td>Long</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcoholic solutions</td>
<td></td>
</tr>
</tbody>
</table>

Ensure handwashing for 5 minutes before surgical procedures
**INFECTION PREVENTION**

**Hand washing**

**Use of protective attire**

**Proper handling and disposal of sharps**

**Ensuring general cleanliness**
(walls, floors, toilets, and surroundings)

**Bio-Medical Waste disposal**
- Segregation
- Disinfection
- Proper storage before transportation
- Safe disposal

**Disposal Bag**

- **Yellow Bag**
  - Human tissue
  - Placenta and PoCs
  - Waste swabs / bandage
  - Other items (surgical waste) contaminated with blood

- **Black Bag**
  - Kitchen waste
  - Paper bags
  - Waste paper / thermocol
  - Disposable glasses & plates
  - Left over food

- **Red Bag**
  - Disinfected catheters
  - I.V. bottles and tubes
  - Disinfected plastic gloves
  - Other plastic material

**Puncture Proof Container**
- All Needles and Sharps
- I.V. Cannulas
- Broken Ampoules
- All Blades

**Needle Destroyer**

**Hand washing**

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PREPARATION OF 1 LITRE BLEACHING SOLUTION

1. Take 1 litre of water in a plastic bucket.
2. Make thick paste in a plastic mug with 3 level tea-spoons of bleaching powder and some water from the bucket.
3. Mix paste in the bucket of water to make 0.5% chlorine solution.
4. Maintain the same ratio for larger volumes.

Wear utility gloves and plastic apron.
PROCESSING OF USED ITEMS

DECONTAMINATION
Soak in 0.5% chlorine solution for 10 minutes

Thoroughly wash and rinse
Wear gloves and other protective barriers

Preferred Method
Sterilisation

Chemical
Soak for 10 - 24 hrs.

Autoclave
106 kPa pressure
121° C
20 min. unwrapped
30 min. wrapped

Dry Heat
170° C
60 min.

Acceptable Method
High Level Disinfection (HLD)

Boil or Steam
Lid on 20 min.

Chemical
Soak for 20 min.

Cool
(use immediately or store)
ANTENATAL EXAMINATION

FUNDAL HEIGHT

Preliminaries

- Ensure privacy
- Woman evacuates bladder
- Examiner stands on right side
- Abdomen is fully exposed from xiphi-sternum to symphysis pubis
- Patient’s legs are straight
- Centralise the uterus

![Diagram showing fundal height](image)

- Correct dextrorotation
- Ulnar border of left hand is placed on upper most level of fundus and marked with pen
- Measure distance between upper border of pubic symphysis and marked point

Fundal height in cms. corresponds to weeks of gestation after 28 weeks

GRIPS

- Legs are slightly flexed and separated for obstetrical grips

![Diagram showing grips](image)

- Fundal Grip
- Lateral Grip
- First Pelvic Grip
- Second Pelvic Grip
- Fetal heart sound is usually located along the lines as shown

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THE SIMPLIFIED PARTOGRAPH

Identification Data

<table>
<thead>
<tr>
<th>Name:</th>
<th>W/o:</th>
<th>Age:</th>
<th>Parity:</th>
<th>Reg. No.:</th>
</tr>
</thead>
</table>

Date & Time of Admission: Date & Time of ROM:

A) Foetal Condition

<table>
<thead>
<tr>
<th>Foetal heart rate</th>
<th>200</th>
<th>190</th>
<th>180</th>
<th>170</th>
<th>160</th>
<th>150</th>
<th>140</th>
<th>130</th>
<th>120</th>
<th>110</th>
<th>100</th>
<th>90</th>
<th>80</th>
</tr>
</thead>
</table>

Amniotic fluid

B) Labour

<table>
<thead>
<tr>
<th>Cervic (cm) (Plot X)</th>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

Alert Action

<table>
<thead>
<tr>
<th>Hours</th>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
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</table>

Alert Line

<table>
<thead>
<tr>
<th>Contraction per 10 min.</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
</table>

C) Interventions

<table>
<thead>
<tr>
<th>Drugs and I.V. fluid given</th>
<th></th>
</tr>
</thead>
</table>

D) Maternal Condition

<table>
<thead>
<tr>
<th>Pulse and BP</th>
<th>180</th>
<th>170</th>
<th>160</th>
<th>150</th>
<th>140</th>
<th>130</th>
<th>120</th>
<th>110</th>
<th>100</th>
<th>90</th>
<th>80</th>
<th>70</th>
<th>60</th>
</tr>
</thead>
</table>

Temp (°C)

Initiate plotting on alert line

Refer to FRU when ALERT LINE is crossed

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KANGAROO CARE

Place baby prone on mother's chest in an upright and extended posture, between her breasts, in skin to skin contact.

Cover the baby with mother’s pallu or gown. Wrap baby-mother with added blanket/shawl.

Keep room warm. Breastfeed frequently.
VAGINAL BLEEDING BEFORE 20 WEEKS

**Threatened abortion**
- c/o pain abdomen and light bleeding P/V
- No h/o expulsion of PoC
- O/E uterus soft, corresponds to POG, os closed

- Advise rest at home
- Consult/Refer to M.O. for ANC

**Incomplete abortion**
- c/o pain abdomen and excessive bleeding P/V
- h/o expulsion of PoC
- O/E uterus size smaller than POG, os may be open

- If bleeding stops
- Consult/Refer to M.O.

- If bleeding does not stop or in shock
- Establish I.V. line and give I.V. fluids rapidly
- Consult / Refer to M.O. with referral slip

**Complete abortion**
- c/o light bleeding
- h/o pain abdomen, bleeding P/V with expulsion of PoC
- O/E uterus size smaller than POG, os closed

- Observe for 4-6 hrs.

- If bleeding continues
- Consult / Refer to M.O.

- If bleeding stops
- Reassure and advise to take rest at home
ANTEPARTUM HEMORRHAGE

VAGINAL BLEEDING
AFTER 20 WEEKS

PLACENTA PREVIA
(Placenta lying at or near os)

ABRUPTIO PLACENTAE
(Detachment of normally placed placenta before birth of fetus)

Establish I.V. line
Start I.V. Fluids
Monitor vitals - PR, BP

NO P/V TO BE DONE

Refer to FRU
Arrange for blood donors
ECLAMPSIA

Convulsions
BP ≥ 140/90 mmHg
Proteinurria

Immediate Management

Position woman on her left side
Ensure clear airway (use padded mouth gag after convulsion is over)
Do gentle oral suction
Give Inj. Magnesium Sulphate
5g (10ml, 50% ) in each buttock deep I.M.

Delivery imminent
Conduct delivery and refer to FRU

Delivery not imminent
Refer immediately to FRU
Management of PPH

Start Inj. Oxytocin 20 IU in 500 ml R/L @ 40-60 drops per minute (in other hand)

Check to see if placenta has been expelled

Placenta not delivered

Retained placenta

Continue Inj. Oxytocin 20 IU in 500 ml, R/L @ 40-60 drops per minute

Refer to FRU

Soft and flabby uterus (Atonic PPH)

Bimanual compression of uterus

Continue Inj. Oxytocin 20 IU in 500 ml R/L / DNS-I/V

Administer another uterotonic drug (Inj. Methergine / Tab. Misoprostol)

Patient still bleeding

Refer to FRU

Placenta delivered

Massage the uterus to expel the clots

Examine placenta & membranes for completeness

Complete

Not Complete

Feel the consistency of uterus per abdomen

Uterus well contracted (Traumatic PPH)

Pack the vagina and refer to FRU

Continue Inj. Oxytocin 20 IU in 500 ml, R/L @ 40-60 drops per minute

Refer to FRU

Give Inj. Oxytocin 10 IU, I.M. (if not given after delivery)

Shout for Help: Mobilise available health personnel.
Quickly evaluate vital signs: Pulse, BP, Respiration.
Establish I.V. Line (draw blood for blood grouping & cross matching)
Infuse rapidly Normal Saline/Ringer Lactate 1L in 15-20 minutes.
Give Oxygen @ 6-8 L per minute by mask (if available)
Catheterize the bladder.
Check vital signs and blood loss (every 15 minutes).
Monitor fluid intake and urinary output.

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After the birth of the baby, exclude the presence of another baby and give Injection Oxytocin 10 units I.M.

Once the uterus is contracted, apply traction (pull) downwards and give counter-traction with the other hand by pushing uterus up towards the umbilicus.

Uterine massage to prevent atonic PPH
**NEWBORN RESUSCITATION**

**Birth**
- **No meconium** - dry the baby
- **Meconium present** - suction mouth and nose (if baby is not crying) and dry the baby

**Routine care**
- Place the baby on mother's abdomen
- Wipe mouth and nose
- Clamp & cut the cord (after 1 - 3 min. of birth)
- Keep baby with mother
- Initiate breastfeeding
- Watch colour and breathing

**Initial steps**
- Cut the cord immediately
- Place on firm, flat surface
- Provide warmth
- Position baby with neck slightly extended
- Suction mouth and then nose
- Stimulate, reposition

**Assess breathing**

**Not breathing well**
- Provide bag and mask ventilation for 30 sec., ensure chest rise. Make arrangements for referral

**Assess breathing**

**Not breathing well**
- Call for help and make arrangements for referral
- Continue bag and mask ventilation
- Add oxygen, if available

**Assess Heart Rate**
(Umbilical pulsation: check for 6 sec. and multiply by 10)

**heart rate ≥ 100**
- Continue bag and mask ventilation
- If breathing well, slowly discontinue ventilation and provide observational care

**heart rate < 100**
- Continue ventilation with oxygen
- Provide advanced care (chest compression, medication and intubation, if M.O. / trained personnel are available)

**Breathing well / crying**

**Breathing well**

**Observation / Care**
- Provide warmth
- Observe colour, breathing and temperature
- Initiate breastfeeding
- Watch for complications (convulsions, coma, feeding problems)
- Refer when complications develop

**Meconium present**
- Suction mouth and then nose (if baby is not crying)
- And dry the baby

**Birth**
- **Not breathing well**
- **Assess breathing**
- **Breathing well / crying**

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BREAST FEEDING

Baby well attached to the mother’s breast

1. Chin touching breast (or very close)
2. Mouth wide open
3. Lower lip turned outward
4. More areola visible above than below the mouth

Baby poorly attached to the mother’s breast
ANTENATAL CHECKUP

Registration and Antenatal checkups during pregnancy:
- Necessary for well being of pregnant woman and foetus
- Help in identifying complications of pregnancy on time and their management.
- Ensure healthy outcomes for the mother and her baby

Preferred Time for Antenatal Checkups*

<table>
<thead>
<tr>
<th>Registration &amp; 1st ANC</th>
<th>In first 12 weeks of pregnancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2nd ANC</td>
<td>Between 14 and 26 weeks</td>
</tr>
<tr>
<td>3rd ANC</td>
<td>Between 28 and 34 weeks</td>
</tr>
<tr>
<td>4th ANC</td>
<td>Between 36 and term</td>
</tr>
</tbody>
</table>

* Provide ANC whenever a woman comes for check up

FIRST VISIT

- Pregnancy detection test
- Fill up MCH Protection Card & ANC register
- Give filled up MCH Protection Card & Safe Motherhood booklet to the pregnant woman
- Patient’s past and present history for any illness/complications during this or previous pregnancy
- Physical examination (weight, BP, respiratory rate) & check for pallor, Jaundice & oedema

CHECK UP AT ALL VISITS (From 1st to 4th)

- Physical examination
- Abdominal palpation for foetal growth, foetal lie and auscultation of Foetal Heart Sound
- Counselling:
  - Nutritional Counselling
  - Educate woman to recognise the signs of labour
  - Recognition of danger signs during pregnancy, labour and after delivery or abortion
  - Encourage institutional delivery/ identification of SBA/avail JSY benefits
  - Identify the nearest functional PHC/FRU for delivery and complication management
  - Pre Identification of referral transport and blood donor
  - To convey the importance of breastfeeding, to be initiated immediately after birth
  - For using contraceptives (birth spacing or limiting) after birth/abortion

ADVISE

- Laboratory investigations
  - Haemoglobin estimation
  - Urine test for sugar and proteins
  - Rapid malaria test (in endemic areas)

At SC:
- Blood group, including Rh factor
- VDRL, RPR, HBsAg & HIV testing
- Rapid malaria test (if unavailable at SC)
- Blood sugar random

At PHC/CHC/FRU:
- Give Iron/Folic acid tablets and two doses of TT injection

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POSTNATAL CARE

Post natal care ensures well being of the mother and the baby.

**Postnatal care**

<table>
<thead>
<tr>
<th>Visit</th>
<th>Time After Delivery</th>
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<tbody>
<tr>
<td>1st</td>
<td>1st day after delivery</td>
</tr>
<tr>
<td>2nd</td>
<td>3rd day after delivery</td>
</tr>
<tr>
<td>3rd</td>
<td>7th day after delivery</td>
</tr>
<tr>
<td>4th</td>
<td>6 weeks after delivery</td>
</tr>
</tbody>
</table>

Additional visits for Low Birth Weight babies on 14th, 21st and 28th days

**SERVICE PROVISION DURING VISITS**

**Mother**

- Check:
  - Pallor, pulse, BP and temperature
  - Urinary problems and vaginal tears
  - Excessive bleeding (Post partum Haemorrhage)
  - Foul smelling discharge (Purperal sepsis)
- Care of the breast and nipples
- Counsel and demonstrate good attachment for breast feeding
- Advice on Exclusive Breast Feeding for 6 months
- Provide IFA supplementation to the mother
- Advise for nutritious diet and use of sanitary napkins
- Motivate and help the couple to choose contraceptive method

**Newborn**

- Check temperature, jaundice, umblical stump and skin for pustules
- Observe breathing, chest indrawing, convulsions, diarrhea and vomitting
- Confirm passage of urine (within 48 hours) and stool (within 24 hours)
- Counsel on keeping the baby warm
- Keep the cord stump clean and dry
- Observe suckling by the baby during breastfeeding
- Make more visits for the Low Birth Weight babies
- Emphasise on importance of Routine Immunisation

**NOTE**: Manage the complications and refer if needed