SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Date:20.10.2019

From
Dr. Kalarani
Professor and HOD,
Department of Obstetrics and Gynaecology
Sri Lakshmi narayana Institute of Medical Sciences,
Bharath Institute of Higher Education and Research,
Chennai.

To
The Dean,
Sri Lakshmi Narayana Institue Of Medical Sciences,
Bharath Institute of Higher Education and Research,
Chennai.

Sub: Permission to conduct value-added course: Labour Ward Drills

Dear Sir,

With reference to the subject mentioned above, the department proposes to conduct a value-added course titled: **Labour Ward Drills** on April 2019 to Jan 2020. We solicit your kind permission for the same.

Kind Regards

Dr.Kalarani,

FOR THE USE OF DEANS OFFICE

Names of Committee members for evaluating the course:

The Dean: Dr. Jayalakshmi

The HOD: Dr. Kalarani

The Expert: Dr. Durga

The committee has discussed about the course and is approved.

Dean

Subject Expert

HOD

Dr. G. JAYALAKSHMI, BSC., MBBS., DTCD., M.D.,
DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram, Kudapakkam Post,
Villianur Commune, Puducherry - 605502.

ASSOCIATE PROFESSOR
DEPT. OF OBSTETRICS & GYNAECOLOGY
Sri Lakshmi Narayana Institute of
Medical Sciences
OSUDU, PUDUCHERRY.

PROFESSOR
DEPT. OF OBSTETRICS & GYNAECOLOGY
Sri Lakshmi Narayana Institute of
Medical Sciences
OSUDU, PUDUCHERRY.

SRI LAKSHMI NARAYANA INSTITUTE OF MEDICAL SCIENCES

Circular

15.12.2018

Sub: Organising Value-added Course: Labour Ward Drills - reg

With reference to the above mentioned subject, it is to bring to your notice that Sri Lakshmi Narayana Institute of Medical Sciences, **Bharath Institute of Higher Education and Research**, is organizing **"Labour Ward Drills"**. The course content and registration form is enclosed below."

The application must reach the institution along with all the necessary documents as mentioned. The hard copy of the application should be sent to the institution by registered/ speed post only so as to reach on or before 30.12..2018. Applications received after the mentioned date shall not be entertained under any circumstances.

DEAN

Dr. G. JAYALAKSHMI, BSC., MBBS., DTCD., M.D.,
DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram, Kudapakkam Post,
Villianur Commune, Puducherry-605502.

Course Proposal

Course Title: Labour Ward Drills

Course Objective:

1. **Obstetric emergency -overview**
2. **Conduct of an Labour drills**
3. **Practical skills - PPH**
4. **Practical skills - Maternal collapse**
5. **Practical skills - Eclampsia**
6. **Practical skills - Sepsis**
7. **Practical skills - category 1 C-section**
8. **Problem based case scenario**
9. **Role of anaesthesia in emergency**
10. **Role play**

Course Outcome: To gain Knowledge about Labour Ward Drills

Course Audience: Final MBBS Undergraduates

Course Coordinator: Dr.DURGA

Course Faculties with Qualification and Designation:

1. **Dr. Kalarani, Prof. and HOD, OG**
2. **Dr. R. DURGA, Assistant Professor, OG**

Course Curriculum/Topics with schedule (Min of 30 hours)

SlNo	Date	Topic	Time	Hours
1	2.01.2019	Obs emergency - overview	4.00pm -7.00pm	3
2	10.01.2019	Conduct of an labour drill	4.00pm -7.00pm	3
3	8.02.2019	Practical skills - PPH	4.00pm -7.00pm	3
4	16.02.2019	Practical skills - Maternal collapse	4.00pm -7.00pm	3
5	3.03.2019	Practical skills -Eclampsia	4.00pm -7.00pm	3
6	12.03.2019	Practical skills - Sepsis	4.00pm-7.00pm	3
7	26.03.2019	Practical skills - Category 1 C SEC	4.00pm -7.00pm	3
8	5.04.2019	Problem based case scenario	4.00pm -7.00pm	3
9	11.04.2019	Role of Anaesthesia in emergency	4.00pm -7.00pm	3
10	25.04.2019	Role play	4.00pm -7.00pm	3
			Total Hours	30

REFERENCE BOOKS: (Minimum 2)

1. **Willaims Obstetrics Edition 21**
2. **Strat OG**

VALUE ADDED COURSE

1. Name of the programme& Code

Labour Ward Drills OBGY 10

2. Duration& Period

30 hrs & JANUARY 2019 TO JUNE 2019

3. Information Brochure and Course Content of Value Added Courses

Enclosed as Annexure- I

4. List of students enrolled

Enclosed as Annexure- II

5. Assessment procedures:

Multiple choice questions- *Enclosed as Annexure- III*

6. Certificate model

Enclosed as Annexure- IV

7.No. of times offered during the same year:

1-JANUARY 2019 TO JUNE 2019

8. Year of discontinuation: 2020

9. Summary report of each program year-wise

Value Added Course					
Sl. No	**Course Code**	**Course Name**	**Resource Persons**	**Target Students**	**Strength& Year**
1	OBGY 10	LABOUR WARD DRILLS	Dr. K.DURGA	FINALYEAR MBBS	JANUARY 2019 TO JUNE 2019

10. Course Feed Back

Enclosed as Annexure- V

RESOURCE PERSON

ASSOCIATE PROFESSOR
DEPT. OF OBSTETRICS & GYNAECOLOGY
Sri Lakshmi Narayana Institute of Medical Sciences
OSUDU, PUDUCHERRY.

COORDINATOR

Dr. G. JAYALAKSHMI, BSC., MBBS., DTCD., M.D.,
DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram, Kudapakkam Post,
Villianur Commune, Puducherry - 605502.

PARTICIPANTS BOOKLET

LABOUR WARD DRILLS

INTRODUCTION

Asmassiveobstetrichemorrhageistheleadingcauseof maternalmortalityworldwideandamajorcontributor to maternal morbidity, this subject deserves center stageinthetrainingofmidwiferyandobstetricstaff. Thatthistrainingneedisglobalishighlighted by instancesofsubstandardcarewithdeathsasaresultof postpartumhemorrhage(PPH)inrecentUKconfi- dential reports (CEMACH).

Although much knowl- edgecanbegainedatthebedside,practicalteaching with a structured approach to this unique life- threateningemergencyprovidesasenseofsecurityand preparedness that cannot be obtained in any other manner. Several well-established courses focus on practical emergency teaching, and further information isavailablethroughthewebsitesofmanyprofessional organizations.

SomeofthecoursesrunintheUKand abroadarelistedinAddendumAattheendofthis chapter. These courses present a structured approach to resuscitation with skills, drills and scenarios taught andappliedtotheseriouslyillpatient.Asgoodassuch coursesmaybe,however,theycannotbegintotrain everyoneinallthings,andthereremainsaneedfor stronglocalsupplementationintheformofmulti- disciplinarytraining.Indeed,thelatterhasbeenshown tobeeffectiveinimprovingknowledgeandclinical outcomes.

PRACTICAL TEACHING

Thesamepreparationsshouldbemadewhetherteachingskills,drillsorscenariosaretobeused(seebelow).

Knowledge

Asoundknowledgebaseisrequiredbeforepractical teaching can be undertaken successfully. An initial lecture/workshop/discussionshouldbeorganizedif staffareunfamiliarwithpracticalteachingorif new materialistobetaught,asthisallowsstafftoprepare themselves.Italsohelpsreinforcetheideathatpracticalteachingisanopportunitytoputwhatoneknows intopractice.

Environment

Asuitablelocationshouldbefoundthatisconducive totheteachingthathasbeenplanned.Thelayoutof theroomshouldallowthoseinvolvedtoaccessthe patient(iftheteachingispatientoriented)andthose watching to see clearly. Heating and ventilation shouldbeconsidered,butacousticsarevitalandcan sometimesconflict(e.g.noisefromanopenwindow).

Whenteachingaboutobstetrichemorrhage,adelivery roomoranoperatingtheatermakesforaveryrealistic teaching environment, but it occasionally conflicts withclinicalneeds.Toavoidthis,onecanplan impromptuteachingwhenthedeliverysuiteisquiet. Impromptu or ‘unannounced’ teaching also is good fortestinghowthesystemsareworking(i.e.drills), but,asitdoesnotallowpriorplanningintermsof whoorhowmanypeoplecanbetaught,itmaybeless usefulwhenrunningclinicalscenarios.

Anotheralter- nativeistoconsiderreducingelectivesurgerytofacilitatetraininginanoperatingtheateratagiventime, remembering, of course, that labor ward workloads aretotallyunpredictableandaback- upteachinglocationneedstobeavailable(forexample,aseminar roomorantenatalclassroom).

Setting the tone

Theinstructorshouldgiveageneralexplanationatthe beginningoftheteachingsessioninordertoestablish themoodandmotivatethelearnersbyoutliningthe usefulnessofthecontent.Asimpleintroductionisall thatisrequired.Forexample,'Obstetrichemorrhage is the leading cause of maternal death globally,and todaywearegoingtorunthroughasimulatedcaseof placentalabruption.

Theaimisforyoutoconsolidate andapplyyourknowledgeinthisarea,aprocess whichshouldassistyouwhenyoufaceasimilarsituationinarealemergency'.Atthisstage,italsomaybe usefultointroducetheclinicalprobleminthecontext ofrecenteventseitherlocallyorsomethingthatmay havebeenreportedinthelaypress.

Thespecificobjectivesofthesessionshouldthenbe explainedalongwithwhatisexpectedofeveryonein termsofwhoisgoingtodowhat,andwhetherquestionscanbeaskedthroughoutorbekepttilltheend. Itisextremelyusefultoallowquestioningthroughout, asmanypeoplewillforgetifaskedtowaittilltheend. However, this process can spoil the momentum ofa scenarioandroleplaysessionandmustbejudged anew in eachsession.

Dialogue

Theactual'doing'inpracticalteachingandroleplay worksthroughthesimulationthatcomefromstarting fromveryspecificinstructions.Progresscanvary accordingtowhatthelearnerdoes,andtheinstructor needstostayalertandflexibleinordertoremainin control, to cover all intended teaching points andto guidethesessiontoanappropriateconclusion.

Feedback

Thisissometimesknownascritiqueordebriefingand isanessentialpartofthelearningprocessasitpro-motesretentionofimportantpoints.Anumberof techniquescanbeused,butthemainideaistoidentify and promote the good (salient) points(remembering othersintheteachinggroupmaynothaveknown thesebeforehand)andtoidentifyinasensitivefashion, anydeficiencies(lackofknowledgeorerrors).

One form of systematic feedback, describedby Pendleton and known as Pendleton's rules,comprises fourstages:thelearnersayswhatshe/hedidwell;then whatshe/hecouldimproveupon;thisisfollowedby thetrainerstatingwhatthelearnerdidwell;followed by what could be improved upon. Allowing the learner to comment first provides the instructor an opportunitytoassessthecandidate'sinsightintoheror hisownabilityandbehavior.Theinstructorthenhas the opportunity to highlight both good practice and areasforimprovementnotalreadycoveredbythe learnerinordertostressandreinforcelearningpoints to allpresent.

Anothermethodoffeedbackinvolvesdebriefingas alearningconversation.Thisislessrigidinstylecom-paredwiththeaboveandinvolves:

Makinganopeninggambit(individualizedstartto theconversationdependingonhowthingswent, such as 'That seemed to go well, what doyou think?'or'Thatwasratherdifficult,let'sseeifwe canworkoutwhatwasgoingon'etc.);

Jointly exploring any issues that emerge (listening andresponding,andinvolvingthewholegroupto widentheconversationasneeded);

Sharethoughtsofwholegroupandtheinstructor considering the learning of the whole group, whilebeingcarefulnottooverloadthepractice candidate.

Closure

Bearinginmindthatadultsneedtounderstandsome- thing before they change their behavior, it iscrucial thatquestionsanddiscussionbeencouraged.Asum- mary of the key learning points from the session shouldthenbeprovided,sothateveryoneleavesthe teaching/learning with a clear message of the most importantissues.

DRILLS, SKILLS AND SCENARIOS

Thesethreestylesofteachingdifferintheiraims.Each requiresandtestsdifferentskillsandknowledge,the featuresofwhicharesummarizedinTable1,together withexamplesofsuitableteachingmaterial.

Drills

Thesearepracticeor‘dummy’runsandarecomparabletofirepracticesintestinglocalsystems.Runninga drillnotonlyallowslocalscrutiny(i.e.whatactually happenswhenthealarmisputout),butalsocanbea veryeffectivetestoflocalarrangementsandservicesas wellasstaffknowledgeofthem.

Preparations for a drill

Whenrunningdrills,thestaffshouldbefacedwiththe drillinanormalclinicalarea,unprepared,inorderto receivearealisticideaofwhatwouldhappenina truesituation.Clearly,adrillshouldnotconflictwith patientcare,andtimingmustdependtosomeextent onexistingworkload.Theleadclinicianfortheteachingsessionshould,however,haveinformedthelead midwifeand,inthecaseofanobstetrichemorrhage, the transfusion hematologist and other necessaryindi- viduals,suchastransportationstaff.Thisisnotonlyas amatterofcourtesy,butalsotoplantimingsinorder to avoid clashes of interests. Thetransfusionhematologistmaypreparespareserumforgrouping andmakeemptybloodbagsavailableforthe‘dummy run’.

Running the drill

Figure 1 illustrates an example of an assessmentsheet for a massive obstetric hemorrhage drill,suggesting thingsthatcanusefullybemonitoredincluding:

1. Whorespondstotheinitialemergencybuzzer?
2. Istheappropriateemergencycallputout?
3. Howeffectiveistheemergencybleepingsystem?
4. Istransportationalertedandrespond?
5. Dotransfusionstaffreceiveanycommunication?
6. Howquicklydoesbloodarriveatthebedside?
7. Howquicklyisthepatienttransferredtotheoper- atingtheater?
8. Whendoestheanesthetist/consultant/hematologist arrive?

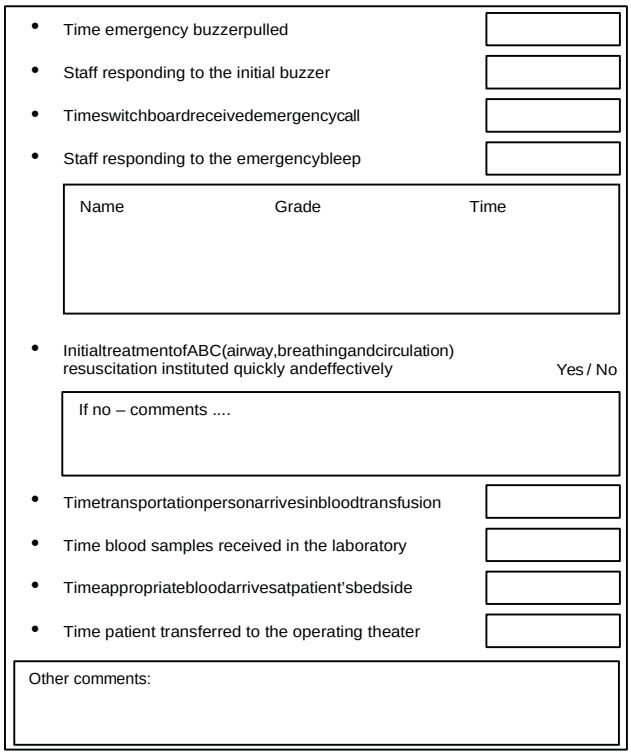

Figure 1 An assessment sheet for massive obstetric hemorrhage drill. This assessment sheet can be expanded to include the response times for individual doctors, and their reactions and action.

Table 1 Key features and differences in skills, drills and scenario teaching

	Skill	*Drill*	*Scenario*
Definition	Acquisitionofaskill	Achainofeventsinresponsetoaproblem	Improvizedclinicalroleplay
Aimoftheteaching	Ensurecorrecttechnique	Testthelocalemergencysystem	Applyandpracticeclinicalcareina improvized set-up
Teachingenvironment	Seminarroom	Throughouthospitalinday-to-day environment	Seminarroom,operatingtheateror deliveryroom
Examples of things suitable for teaching and testing in relation to obstetric hemorrhage	Brace suture Rusch balloon Aortocaval compression CPR Bimanual uterinecompression IV cutdown	Responsetotheemergencymassive obstetric hemorrhagecall	APH – abruption – placental previa PPH – atony – trauma – RPOC
Skillmix	Doctorsandmidwives	Alldeliverysuitestaffandlaboratorystaff, hematologists andporters	Multidisciplinary: obstetricians, midwives, anesthetists, pediatricians

CPR, cardiopulmonary resuscitation; APH, antepartum hemorrhage; PPH, postpartum hemorrhage; RPOC, retained products of conception

Suchanalysescanhelptoillustratesystemfailuresand modify local policies. The identification of problems stimulates and informs development of appropriate guidelines.Clarifyingtherolesofdiversestaffand streamliningactivitycanalsoimprovefutureresponses and improve care. Such developments can bemonitoredatfuturedrillsandimprovementsinthesystem should be fed back to staff. Having run drills for obstetric hemorrhage at Queen Charlotte's and ChelseaHospitalformanyyears,thefollowingare examplesofproblemsidentifiedandsystemchanges made inresponse.

Communication problems and how they were addressed As identified in numerous Confidential Enquiries,problemsincommunicationoftenhamper emergencyresponses.Wefoundthatwestruggled withinstructionsfromclinicianstobloodtransfusion staffregardingwhatwasneededandwhenitwas needed:Wasitpossibletowaitforgroup-compatible bloodorevencross-matchedblood?Howlongtowait tohavebloodatthebedside?Whatclottingproducts wereneededwhen?Thesearesomeexamplesofquestionsthatareoftennotclarified'overthephone'. Itsoonbecameobviousthatthisjobwasnormally delegatedtosomeoneveryjunioronthedeliverysuite andmisunderstandingswerecommon.
Ourresponsewasfirst,toinstallaredphoneinthe obstetricoperatingtheaterbasedonthedeliverysuite thatlinkedexclusivelywitharedphoneinthetransfusion laboratory. This enabled blood requirementsto bediscussedbytheanesthetistdirectlywithtransfusion staffwithouthavingtoleavethepatienttogooutside thetheater.Second,wethenidentifiedtimelimitsfor transfusingbloodatthebedside(forexample,'We need4unitsofbloodwithin30minutes'),ratherthan discussing whether to wait for blood to be cross-matchedornot.Thisleftthelaboratoryinnodoubtof the clinical needs and has minimized delay inblood arrivingatthebedsidewhenneeded.

Problems with transportation and how they were addressed In the past, the transportation person arrivedinthedeliverysuitewhenahemorrhagecall wasputouttotakebloodsamplestothelaboratoryfor grouping/cross-matching;however,thiswasdeemed inefficientanddelayedbloodbeingbroughttothe bedsideinthemosturgentcases.

Oursolutionwasfirsttochangetheprocesssothat thetransportationpersonwentstraighttothelaboratoryinreadinessfortheurgentneedofcollecting O-negativeblood.Second,apneumaticchutewas installedforsamplestobesenttothelaboratorywhich hasalsohelpedinthiscontext.Iftheclinicalcondition ofthepatientcanwaitforgroup-compatibleblood, thetransportationpersonstaysinthetransfusionlaboratoryuntilthesamplehasarrivedbychuteandhas been grouped, ultimately bringing the appropriate bloodtothedeliverysuite.Thistypeofthinkingis especially relevant in large modern hospitals where clinicalandlaboratoryservicesarenotonlyondifferentfloorsbutindifferent,oftenwidelyseparated, buildings.

Skills

Theteachingofpracticalskillsisofgreatimportance inobstetrichemorrhageteachingsessions.Theneed for specific teaching often becomes apparentduring thediscussionandquestioningwhenrunningascenario.Thingsmayhavebeenmentionedwhichare notfullyunderstood,andsuchcircumstancesillustrate howimportantitisforscenarioteachingtobeconstructive(seebelowforexamples).Staffmustfeelable toquestionwhatsomethingisorhowitisdone.In obstetric hemorrhage, the following skills maybe highlightedandneedtobetaught:

1. Medicalskills
2. bimanual uterinecompression
3. aorticcompression
4. cardiopulmonaryresuscitation
5. Surgicalskills
6. insertionofaninflatableuterineballoon
7. insertion of a Bracesuture
8. intravenouscut-downforvenousaccess.

Preparation for skills teaching

Teachinganypracticalskillthatmayberequiredinan emergency, should be executed slowly and calmly, givingampletimeforreflection,questionsandpractice.Theuseofmanikinsandsurgicalaidsworkswell, butonemustremembertopointoutthedifferencesto beexpectedwhenworking*invivo*(suchastheneedto keepaninflatableuterineballoonwellintothecavity whileinflatingit,orhowtodealwiththetendencyfor thebracesuturetoslipofftheuterinecornualareas (‘theshoulders’)whilepullingittight).

Running the skills teaching

Thisteachingprocessisbestperformedinfoursteps:

1. *Step 1* The instructor demonstrates the skill in silence.Theskillisperformedatnormalspeedsothat thecandidatesappreciatetheultimateaim.
2. *Step 2* The instructor then demonstrates the skill slowlywithacommentary.Providingthecommentaryandbreakingthetechniquedownaddsunders tanding to the process and can highlight points ofcautionandsafetyaswellasaddinghelpfulhints.
3. *Step3*Thelearnerprovidesthecommentary,which theinstructorfollowswhiledemonstratingtheskillfor thethirdtime.Theinstructormustbecarefulnotto assume knowledge on the learner’s part during this processandstopinmid-flowiferrorsaremade.This stepiscrucialintermsofsurgicalsafety,astheinstructorcantellwhatthelearnerunderstands.Anyerrorsor omissions can be addressed immediately. This step may need to berepeated.
4. *Step 4*Once step 3 is completed satisfactorily, the learnerisallowedtoperformtheskillwhileproviding acommentaryunderdirectsupervision.

Scenario teaching

Thesepracticalteachingsessionsdescribeaclinical pictureandfacilitateroleplaytomanagetheproblem. Theaimofsuchteachingistodemonstrateappropriate clinical behavior, including not only whether an individualhastherequisitelevelofclinicalknowledge andhowitisapplied,butalsohowindividualswork together as a team and communicate. Suchinteractionscanbecomplexandareworthdescribingfurther beforeillustratingmassivehemorrhagescenarios.

Teamwork

Theabilitytoworktogetherasateamisabsolutely requisitetogoodclinicalcare.Individualspossessdif-feringlevelsofexpertise,andthegroup’sabilityto carryoutspecifictasksdependsupontheinterpersonal skillsofallteammembers.Watchingagroupworking togethercanhighlightitsproblemsandhelpfocus remedialactionintermsofteamwork(orlackthereof) andoccasionallyindividualbehavior.

Everyteamneedsaleader,anddecidingwhothe leaderistobecansometimesbedifficult.Itisimpor-tanttorecognizethattheteamleaderneednotbe themostseniorpersonand,asthescenariodevelops,

sometimes the leader will need to change. In any event,theleadershouldhaveappropriateknowledge andskills,beagoodcommunicatorandmotivator,be able to maintain situation awareness (see thewhole picture)anddistributetheworkload.Atthesame time,watchingstaffadapttoeachothercanbehugely instructive,anddiscussingtheseissuesafterwardscan helpthemunderstandeachother,aswellasindividual needs andstresses.

Communication

The process of asking for and providinginformation andoflisteningtowhatotherpeoplearetryingtosay shouldbesimple.Itclearlyisnot,however,andis repeatedly raised as a problem area in Confidential Mortality Reports. In the Confidential Enquiry Report of 1997–1999[6], the greatest (and recurrent) causeofsubstandardcareinmaternaldeathswasfailure of communication and team workingbetweenprofessionals. When running practical teachingsessions,communicationwithintheteamcanbewitnessed and discussed afterwards. Generally speaking, when dealing with any emergency, singleprecise commandsshouldbeaddressedtospecificindividuals. Voicesshouldnotberaisedandanairofcalmcontrolideallyshouldbeapparent.Unfortunately,some individualstendtobecomeoverexcited,andnoise levelscanbuildupinemergencysituations,allof whichcanaffecteveryone'sbehavior,aswellasmake itexceedinglydifficulttohearwhatisbeingsaidwithout resorting to shouting. Pointing out such behavioralfeaturesunderstressduringmockemergencies canonlyhelptoraiseawareness.

Preparingforscenarioteaching

Whenpreparingforroleplay,itisimportanttotryto makethingsasrealisticaspossible.

ThepatientDependingonthesubject,eitheramanbegoodforcollapseandcardiopulmonaryresuscitationeneeded(forexample,themodelcanpretendtofit abruption).Eithercansuitmassiveobstetrichemoreveryoneusuallylearnsagreatdealwithregardtohow emergencies ikinoralivepersonisappropriate.Manikinstendto tion,whereaslivemodelsarebetterwhenresponses ineclampsia,orcangroananddescribepainwithan rhage.However,theadvantageofalivemodelisthat alllevelsofstaffcommunicatewithapatientinsuch

The equipmentRunning clinical scenarios is more realistic if appropriate equipment is available. This maybequitesimple(e.g.lateraltiltandoxygen,but usingithelpstoillustratewhatimportantfeatureshave been dealt with and what omissions have occurred (e.g.intravenousaccessorurinarycatheter).Table2 suggestsaminimumequipmentlistforamassive hemorrhagescenario.

Table 2 Basic equipment list for practical obstetric hemorrhage training

Airway and breathing
Guedel airway
Oxygen mask with bag and tubing Stethoscope
Circulatory
Wedge(toprovidelateraltiltforthepelvis) Tape
Two large-bore intravenous cannulae (14 F) 20-ml syringe
Bloodtubesforfullbloodcount(FBC),cross-match(XM),clotting studies
2-literbagsofcrystalloidrunthroughadministrationsets Catheter

Specific equipment for massive obstetric hemorrhage
Intrauterine inflatable balloon and bladder syringe

Running the scenario

1. *Who should be involved?* It is often difficult to decidewhoshouldbeinvolvedintheroleplayand whoisbetterlefttowatchquietly.Ifstaffmembersare inexperiencedwithscenarioteaching,itisbestinitially toaskforvolunteers.Lackofvolunteersmaybedueto simplefactorssuchasbeingshy,butitmayresultfrom fearofignorancebeingexposedorraisingissuesof competency.Itisforthisreasonthatdidacticteaching isabsolutelyrequiredpriortorunningscenariotrain- ing,sothatthetheoreticalmaterialhasalreadybeen covered. If this has taken place, thosepreviously unsureofthetheorybehindtheproblemcanbuildon theirnewlyacquiredknowledgeinapracticalway. Indeed,oncemembersofstaffbecomeusedtothis methodofteaching,morewillcomeforward.Occa- sionally,someonemayneedtobeinvitedtojoinin, butthisshouldbedonesensitivelyandwithsupport.
2. *Give people defined roles*People need to be given a definedroleandtoldwhattheycanorcannotexpect intermsofback-up.Forexample,'Youarethesenior house officer who has just answered theemergency buzzertothismultiparouspatient.Shehasjustbled briskly following spontaneous vaginal delivery. The midwifeishere,butallotherstaffarebusywithan emergencyintheaterandyoushouldnotexpecthelp foratleast10minutes.Pleasecarryonasyouwouldin reallife.Iwillgiveyouanyobservationsyourequest.
3. *Keeping the scenario going* The patient can be primedtogivecertainresponses,andmonitorscanbe preparedwithreadings(cardiotocographpaperstick- ingoutofamachine/bloodpressurerecordingsona monitor,etc.),butitistheinstructor'sroletokeepthe scenarioflowingandgiveasmuchoraslittleinforma- tionasisrequested.Thescenarioneedstoprogress, however, and gentle encouragement andoccasional subtlepromptscanassistthelearnerinachievingan understandingofthekeytreatmentpoints.Theaimof runningscenariosisnottodemonstrateignoranceon thepartofoneormoreindividuals,buttoempower themtoapplytheirknowledgeinalogicalandtimely manner.Dependingontheperformanceandabilityof thecandidate(s),thescenariocanberesolvedearlyor becomemorecomplex.Thisshouldbeanticipatedby the instructor well in advance. If the candidateis becomingstressed,buthasdoneallthebasickeytreat- mentpoints,thenthescenariocanresolveandthe candidatecanbecongratulated.Ifthekeytreatment pointshavenotbeenachieved,ontheotherhand, thenhelpcanbeathandintheformofaregistraror consultantarrivingtohelp.Ifthelearnerisdoinga fantasticjob,thenthescenariocanprogressandmore complex features can beadded.
4. *Prompting* This can be difficult if it is to be done sensitivelywithoutdemoralizingorembarrassingthe learner;inreality,itrequiresskillandtacttomake this form of teaching constructive.

Thefollowing examples may be useful in the massivehemorrhage situation:

- Lateraltiltcanbeforgotteninthepregnantwoman andapromptaskingwhetherthereis'anythingelse

that could improve the circulation?' may jog a response

- Ifthecandidatehasnotregisteredorrespondedto worryingobservationssuchasatachycardiaor hypotensionthenthesecanberepeatedandmade worse, e.g. 'the tachycardia has now increasedto xxx or the blood pressure is now yy/zzor unrecordable'
- Comment that uncross-matched blood is now availableifstaffhavelosttheirtrainofthoughtand had already mentioned they would request blood but then forgotten aboutit
- Providing the patient's physiological responses can slowdown/speeduptheactionasrequired.For example, once intravenous fluids have commenced, informthecandidatethatthebloodpressureis improving but that vaginal bleeding is still brisk. Thiswillencouragethecandidatetomoveonto assess thecause
- Ifthecandidatemovesawayfromtheintravenous accesswithouttakinganybloodsforlaboratory investigation,theinstructormayslowthingsdown byaskingifshe/hewoulddoanythingelsebefore movingontoassessthecauseofthebleeding.The candidate could also be prompted with an empty syringeandbloodtubes,ifnecessary,tomakea teachingpoint.

5. *Drawing things to a logical conclusion* When the scenariohasrunitscourse,allpeoplewhohavebeen involvedintheroleplayshouldbecongratulatedand thankedfortheirparticipation,andthenencouraged toengageinthefeedbackprocessasdescribedabove. Questions and discussion should then be encouraged beforeclosure,withparticularemphasisgiventothe key treatmentpoints.

Examples of possible massive obstetric hemorrhage scenariosareprovided,togetherwiththeirkeytreatmentpointsinAddendaBandC.

SUMMARY

Setting up practical teaching locally improves local processes, builds on teamwork, aids with communication,andimprovesclinicalknowledgeanditsapplicationintheemergencysituation.Itisbestkeptsimple and, because it can be stressful to those involvedin roleplay,itmustbeintroducedsensitivelyandconductedwithinanencouragingatmosphere.Staffneed toknowwhatstyleofteachingwillbeused,andwhat itaimstoaccomplish.Advertisingtheplannedcontent ofthesessioninadvancewillencouragestafftoprepareandcapitalizeonenthusiasmandlearning.Good luck.

SamplescenarioforPPHduetoatonic uterus

Instructor's information

ThisscenarioisoneofPPHduetouterineatony.You arelookingforrapidresuscitationofthewomanatthe sametimeasdiagnosingandtreatingtheproblem (uterine compression, evacuation of clots, administra- tionofuterotonicdrugsandcheckingfortrauma). Dependingonhowthescenarioflowsyoucanallow forrapidrecovery,ornot– ifbleedingpersiststhere canbediscussionaboutothercausesofhemorrhage andyouarelookingforanearlydecisiontogotothe - aterforanexaminationunderanesthetictoexclude trauma/retainedproducts.

Candidate information

A34-year-oldgrandmultiparadeliveredahealthy babyboyweighing4.00kg40minutesago.Shehad physiologicalmanagementofherthirdstage,andthe placentawasdelivered10minutesago.Themidwife hasnoticedfreshandbriskvaginalbleedingandaccosts youasyouwerewalkingpastthedeliveryroom.

Initial observations

Thepatientistalkingbutverypale;pulse110/min; bloodpressure120/80mmHg;largevolumeofblood onbedandfloor.Pleaseproceedasyouwouldinreal lifetogetherwiththemidwifewhocalledyou.Iwill giveyouanyobservationsyourequest.(Thecandidat e canbeobstetricormidwiferyaseithershouldbeable tomanagethisemergency.Iffurtherprogresstotheater isneeded,moreseniorhelpcanarriveasrequested.)

Instructor'snotes/Keytreatmentpoint stobe achieved

- Callforhelpandinitiatethemassiveobstetrichem - orrhagedrill
- Recognizethatthisisacirculatoryproblem:prog- ressrapidlythroughairwayandbreathingandattach face mask foroxygen
- Establish intravenousaccess
- Sendbloodforfullbloodcount,cross- match,coag- ulation andU&Es
- Commencewarmedintravenousfluids
- Do clinical examination and diagnose uterine atony
- Administertransabdominaluterinemassage
- Administer a uterotonicagent
- Performavaginalexaminationandevacuateclots
- Checkforobviousvaginalorcervicallaceration s
- Do bimanual uterinecompression
- Gothroughmedicationcascadelogicallyandgiv e intravenousfluidsandbloodappropriately
- Consider examination under anesthetic ifpatient failstorespondandconsiderothercausesofPPH
- Knowledge of surgical techniques to controlhem- orrhage,i.e.Rüschballoon,bracesuture,etc.

Thisscenarioismorecomplex–aprecipitatelabor withthepossibilityofaconcealedabruptionorgenital tract trauma. The focus will be ondistinguishing betweenabruption,genitaltracttraumaandretained products/membranes with/without disseminated intravascularcoagulation(DIC).Howthisscenariowill unfoldwilldependonthelearner'sexperienceand ability.Youarelookingforrapidresuscitationofthe womanatthesametimeasdiagnosingandtreatingthe problem (uterine compression, evacuation of clots, administration of uterotonic drugs and checkingfor trauma).Onthisoccasionbleedingpersistsandyouare lookingforanearlydecisiontogototheaterforan examination under anesthetic. For a junior traineeyou maychoosetoletthemfindandrepairavaginalor cervicaltear,butforaseniortraineeyoucantakethem furtherwithDIC,bloodandclottingproducts,checkingforacidosisandneedforventilation,etc.

Candidate information

A24-year-oldprimiparaisinducedat42weeks'gestation.Sheishavingintermittentabdominalpainwhen the prostaglandin is inserted. One hour later she is transferredtothedeliverysuiteinextremepainand20 minutes later she delivers a 3.8 kg baby boyrapidly followed by theplacenta.

Initial observations

Talking; pulse is 100/min; blood pressure 115/70 mmHg; steady trickle of blood vaginally.

Pleaseproceedasyouwouldinreallifeand Iwill giveyouanyobservationsyourequest.

Instructor's notes/Key treatment points achieved

- Callforhelpandinstitutemassivehemorrhagecall
- Recognize circulatory problem. Move swiftly throughairwayandbreathing.Administerface maskoxygen
- Insert intravenousaccess
- Sendbloodforfullbloodcount,crossmatchand coagulationscreen
- Commencewarmedintravenousfluids
- Abdominal examination to confirm uteruswell contracted
- Vaginal examination to check for vaginal lacerations
- Transfertotheaterforanalgesiaandexamination
- Catheterize
- FullEUA:checkvagina,cervixanduterinecavity
- Iftraumafound–timelyrepair?
- If products membranes remaining – evacuation performed?

IfDIC–knowledgeofbloodproducts,significance of acidosis, need forITU

Emergencies on the labour ward may have obstetric, anaesthetic, or general

medical causes.

The response to any urgent call to labour ward must adopt an ‘ABC’ approach with early recognition of problems specific to the parturient. There is good evidence that mandatory skills and drills training can improve outcome in emergency situations.
Obstetric anaesthetists primary role in the maternity unit is the provision of anaesthesia and analgesia to women in labour and who require Caesarean delivery. In addition, they are essential members of the multidisciplinary team who will assist with the management of the various types of emergency that can arise in the maternity unit.

Emergency problems in obstetric patients pose a unique set of challenges....

These situations are generally rare, so even experienced clinicians may only have limited experience.

Obstetric units are frequently geographically remote, so clinicians may be working in unfamiliar surroundings.

Obstetric patients are generally fit and healthy, so, faced with a physiological insult, will initially compensate, before deteriorating precipitously, prompting an urgent call for help.

The emergencies that may lead to an urgent call to labour ward are.....

1. **Maternal collapse** is the generic term that may be used to describe the endpoint of a variety of clinical problems. It is defined as ‘an acute event involving the cardiorespiratory systems and/or brain resulting in a reduced or absent conscious level (and potentially death), at any stage in pregnancy and up to 6 weeks postdelivery

• Maternal collapse may arise as a result of pregnancy-related conditions, pre-existing disease, or co-incidentally during pregnancy

Four Hs and four Ts

- Hypoxia
- Hypovolaemia
- Hypothermia
- Hypo- or hyper-kalaemia/- magnesaemia/-calcaemia,
- Thromboembolism
- Toxins
- Tamponade
- Tensionpneumothorax

can be used to classify common causes of collapse in pregnancy, with the addition of eclampsia and intracranial haemorrhage

2. **Maternal cardiac arrest**

• Maternal cardiac arrest is rare, occurring in pregnancies and clinicians may never witness a case of maternal cardiac arrest over the course of their careers.

• Standard Advanced Life Support applies in the pregnant patient with two modifications

(i) The patient should be resuscitated with a left lateral tilt of at least 158 (but ,308) to minimize aorto-caval compression, which reduces the efficacy of chest compressions during resuscitation. •

(ii) Perimortem Caesarean section should begin within 4 min of arrest and be accomplished by 5 min.

a. The primary reason for perimortem Caesarean is to maximize the chance of maternal survival by relieving aorto-caval compression, improving venous return, and promoting transfusion of blood from the placental bed.
b. Once arrest occurs, fetal survival is also optimized by rapid delivery;
c. The best chance of survival for fetuses occurs when delivery occurs within 5 min of maternal arrest.
d. equipment required to perform a perimortem Caesarean section should be kept readily available as standard in any area that routinely cares for pregnant patients.
e. As with all cases of cardiac arrest, consideration should be given to reversible causes while resuscitation continues, Hypovolaemia may be the result of haemorrhage, which may be concealed.
f. Relative hypovolaemia can also occur secondary to vasodilatation, for example, due to sepsis, the leading indirect cause of maternal death in the most recent maternal death enquiry.
g. Cardiac disease, including myocardial infarction, arrhythmias, and cardiomyopathy, was the most common indirect cause of death and should also be considered as a cause of maternal cardiac arrest. • pulmonary or amniotic fluid embolism.

3. **Eclampsia**

- Pre-eclampsia is defined as new hypertension [diastolic arterial pressure (DAP) 90 mm Hg or systolic arterial pressure (SAP) 140 mm Hg] presenting after 20 weeks of pregnancy with significant proteinuria.
- Eclampsia is a convulsive disorder associated with pre-eclampsia.
- Control of arterial pressure
    - In patients with severe hypertension, arterial pressure should be

controlled to SAP of ,150 mm Hg and DAP between 80 and 100 mm Hg, using one of the following agents: • † labetalol (i.v. or orally), • † hydralazine (i.v.), • † nifedipine (orally).

- Before administration of hydralazine, consideration should be given to administering a fluid challenge of 500 ml of colloid, in order to prevent a catastrophic decrease in arterial pressure upon vasodilatation.

Prevention and treatment of seizures

• All patients who suffer eclamptic seizures should be treated with magnesium sulphate.
• A loading dose of 4 g should be administered i.v. over 5 min. This should be followed by an infusion of 1 g h21, which should b continued for 24 h.
• Recurrent seizures should be treated with a further bolus dose of 2–4 g over 5 min
• In contrast to seizures of other aetiology, diazepam, phenytoin, and other anticonvulsants, should not be used in eclampsia.
• At high plasma levels (5–6.5 mmol litre21) magnesium can result in paralysis of respiratory muscles and respiratory arrest. • airway should be maintained, and 10 ml of 10% calcium chloride should be given
• Treatment with magnesium sulphate should also be considered in
• all obstetric patients with severe pre-eclampsia.
This includes:
• † severe hypertension (DAP 110 mm Hg or SAP 160 mm • Hg),
• † mild or moderate hypertension associated with:
• † severe headache,
• † visual disturbances,
• † papilloedema,
• † liver tenderness,
• † clonus,
• † HELLP (Haemolysis, Elevated Liver enzymes, Low • Platelets) syndrome,
• † platelets count decreasing to below 100*109 litre,
• † abnormal liver enzymes.

High ‘spinals’
• The term ‘high spinal’ is used to describe a subarachnoid block that has extended above the higher thoracic dermatomes. However, inadvertently high block can also arise as a complication of epidural analgesia/ anaesthesia.
• There have been no reported deaths secondary to high spinal in the last 20 yr
• Maternal resuscitation has, however, resulted in hypoxic–ischaemic encephalopathy of the baby
• Hypotension and bradycardia secondary to sympathetic block of vasoconstriction and cardiac accelerator fibres. This can be compounded by aorto-caval compression.

• † Respiratory arrest after loss of motor supply to the intercostal muscles and the diaphragm.
• † Loss of consciousness secondary to lack of blood flow and block of the reticular activating system
• After resuscitation, management of a high spinal is essentially supportive.
• High-flow oxygen
• If apnoeic or shows signs of respiratory distress, intubation and ventilation.
• Cardiovascular support consists of i.v. fluids, the use of vasopressors, or ephedrine and atropine.
• Left lateral tilt.
• Fetal monitoring/ and Caesarean delivery may be necessary
• Anaesthesia and ventilation should be continued until the block has receded to the extent that the patient is able to safely maintain their airway and breathe spontaneously.

4. **Haemorrhage**

Haemorrhage is the most common cause of maternal collapse

• post-partum haemorrhage-placenta praevia, placenta accreta, placental abruption

• Uterine rupture, and ectopic pregnancy

• occult bleeding may occur, especially after Caesarean section and ectopic pregnancy.

- Other rare causes of occult bleeding include hepatic rupture and splenic artery rupture.

Initial management should include
• Inserting two large-bore i.v. cannulae,
• Administering high-flow oxygen, and obtaining blood samples for full blood count, coagulation profile, and group and screen.
• Rapid i.v. fluid resuscitation with crystalloid or colloid
• Patient warming
• While resuscitation continues, attempts should be made to identify and treat the underlying cause of haemorrhage. This may require transfer to the operating theatre.
•Coagulation factors should be administered earlier rather than later during resuscitation.

5. **Uterine atony**

Surgical treatments include a
• B-lynch (brace) suture, Rusch balloon insertion, surgical ligation of the external iliac arteries, or hysterectomy.
• Intervention radiology can also be used to identify and occlude a specific bleeding point.

6. Sepsis

• The onset of sepsis may vary from being insidious and non-specific to being overwhelming and rapidly fatal.
• It is characterized by reduced systemic vascular resistance due to vasodilatation, tachycardia, and tachypnoea, and the development of a metabolic lactic acidosis.
• A raised white cell count is commonly associated with sepsis; however, pregnancy also leads to an increase in white cell count, particularly during labour.

Management of the septic pregnant patient
• Resuscitation,
• Identification and
• Treatment of the source,
• Management of complications such as hypotension, and Application of organ protective strategies
• Early haemodynamic resuscitation and hence restoration of adequate oxygen supply to peripheral tissues is a key goal of therapy.
• antibiotics should be administered i.v. and at high dosage.
• Urgent microbiological advice should be sought
• Broadspectrum antibiotics should be given as first-line therapy.
• The source of sepsis should be identified as a priority.
• Swinging pyrexia should arouse suspicion of an abscess or collection, and further imaging,
• And/Or return to theatre for evacuation of products, wound exploration, or laparotomy may be necessary

7. Category 1 Caesarean section

• The classification of the urgency of Caesarean section, recognized by both the Royal College of Anaesthetists and Royal College of Obstetricians and Gynaecologists, is based upon the presence or absence of maternal or fetal compromise.
• Category 1 Caesarean section (the most urgent category) is defined as immediate threat to life of either the woman or the fetus.
• positioning the mother in the recumbent left lateral position,
• administering maternal oxygen at a high inspired percentage, and
• rapid infusion of non-glucose-based crystalloids., oxytocin infusions should be stopped or contractions inhibited, for example, by administering terbutaline 250 mg subcutaneously.
• These measures alone may result in improvement of the CTG, and downgrading of the Caesarean section from Category 1 to Category 2 (no • immediate threat to life

of the woman or fetus).

- Choice of anaesthetic technique
  - General anaesthesia is considered to be faster than regional anaesthesia.
  - Associated with increased maternal morbidity and mortality.
  - spinal anaesthesia for Category 1 Caesarean section—so-called ‘rapid sequence spinal anaesthesia’.

- Principles of this approach include using a ‘no- touch’ technique and using sterile gloves only, utilizing other staff members to perform i.v. cannulation, limiting the number of attempts to one, and preparing the patient for general anaesthesia during attempted spinal insertion.

(10)

VALUE ADDED COURSES

LABOUR WARD DRILLS

List of Students Enrolled January 2019 – June 2019

S.No	Register No	Students List	signature
1	U16MB311	KAVITHA .M	Kavitha.
2	U16MB312	KAVIYA .K	Kaviya
3	U16MB313	KEERTHANA .K	Keerthana
4	U16MB314	KEERTHI K DAS	
5	U16MB315	KUNCHAL BALA VENKATA RAMANA REDDY	Kunchal Bala.
6	U16MB316	LAKSHMIPURAM VEDA SREEVIDYA	Lakshmi
7	U16MB317	LOGESH BABU J.S	J. Logesh.
8	U16MB318	LOKESHWARAN .M	Lokeshwaran
9	U16MB319	MADHUMITHA .R	Madhumitha
10	U16MB320	MADHUMITHA .S	
11	U16MB321	MANIMAARANE .R	Mani.
12	U16MB322	MATHIVAANANE .R	Mathivanan
13	U16MB323	MATHIVANAN .J	Mathivanan
14	U16MB324	MD ALTAF KHAN	A Altaf Khan.
15	U16MB325	MEKALA CHARAN CHOWDARY	Mekala.
16	U16MB326	MERLIN.S	Merlin.
17	U16MB327	MERLINE SHEEBA .B	Merline
18	U16MB328	MOHAN .B	Mohan.
19	U16MB329	MOHIT BHARDWAJ	Mohit Bhardwaj.
20	U16MB330	MONISH PALEI PATRA	Monish Palei Patra

LABOUR WARD DRILLS

MULTIPLE CHOICE QUESTIONS

1 **Which of the following is true statement regarding elliptical incisions ?**

a) Two times as long as it is wide

b) Five times as long as it is wide

c) Four times as long as it is wide

d) Three times as long as it is wide

2 **Consider following statements regarding abdominal incisions :**

1. Transverse incisions tend to be associated with fewer respiratory complications
2. Transverse incisions tend to be associated with better cosmetic outcome
3. Midline incisions tend to be associated with fewer respiratory complications
4. Midline incisions tend to be associated with better cosmetic outcome

3 **Identify true statements from the following ?**

a) Both 1 and 3 are true

b) Both 1 and 2 are true

c) Both 2 and 4 are true

d) Both 3 and 4 are true

4 **For abdominal wall closure, what should be the ration of the length of the suture material to the length of the wound to be closed?**

a) 3:1

b) 4:1

c) 2:1

d) 5:1

5 **Skin grafting is a form of:**

a) Primary Intention Healing

b) Secondary Intention Healing

c) Tertiary Intention Healing

d) Quaternary Intention Healing

6 **In Vascular anastomosis the suture material used should be all except:**

a) Non Absorbable

b) Elastic

c) Non Elastic

d) Monofilament

7 **In Biliary anastomoses, the suture material should have all properties except:**

a) Absorbable

b) Does not promote tissue reaction

c) Should Promote good fibrotic reaction

d) Does not promote stone formation

8 **The diameter of 0 silk in mm is:**

A) 0.500–0.599 B) 0.400–0.499 C) 0.350–0.399 D) 0.300–0.349

9 **Which of the following statement is false about bowel anastomosis?**

A Seromuscular technique is currently the most widely accepted technique of bowel anastomosis

B Extramucosal technique is currently the most widely accepted technique of bowel anastomosis

C Submucosa has a high collagen content

D Submucosa is the most stable suture layer in all sections of the gastrointestinal tract

10 Which of the following is false regarding the absorption of following suture materials:

a) Chromic is absorbed by Phagocytosis and enzymatic degradation

b) Polyglactin is absorbed by hydrolysis

c) Polyglyconate is absorbed by enzymatic degradation

d) Polydioxanone is absorbed at 180 days

REG NO – U16MB323

8/10

LABOUR WARD DRILLS (10)

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Sri Lakshmi Narayana Institute of Medical Sciences

Affiliated to Bharath Institute of Higher Education & Research

(Deemed to be University under section 3 of the UGC Act 1956)

CERTIFICATE OF MERIT

This is to certify that MANIMAARANE has actively participated in the Value Added Course on Labour Ward Drills held during Jan 2019 –JUNE 2019 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

RESOURCE PERSON

ASSOCIATE PROFESSOR
DEPT. OF OBSTETRICS & GYNAECOLOGY
Sri Lakshmi Narayana Institute of
Medical Sciences
OSUDU, PUDUCHERRY.

COORDINATOR

Dr. G. JAYALAKSHMI, BSC., MBBS., DTCD., M.D.,
DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram, Kudapakkam Post,
Villianur Commune, Puducherry- 605502.

Sri Lakshmi Narayana Institute of Medical Sciences

Affiliated to Bharath Institute of Higher Education & Research

(Deemed to be University under section 3 of the UGC Act 1956)

CERTIFICATE OF MERIT

This is to certify that MADHUMITHA .S has actively participated in the Value Added Course on Labour Ward Drills held during Jan 2019 –JUNE 2019 Organized by Sri Lakshmi Narayana Institute of Medical Sciences, Pondicherry- 605 502, India.

RESOURCE PERSON

ASSOCIATE PROFESSOR
DEPT. OF OBSTETRICS & GYNAECOLOGY
Sri Lakshmi Narayana Institute of Medical Sciences
OSUDU, PUDUCHERRY.

COORDINATOR

Dr. G. JAYALAKSHMI, BSC., MBBS., DTCO., M.D.,
DEAN
Sri Lakshmi Narayana Institute of Medical Sciences
Osudu, Agaram, Kudapakkam Post,
Villianur Commune, Puducherry-605502.

Annexure 4

Course/Training Feedback Form

Course:
Date:
Name:
Reg NO.
Department: Obstetrics and Gynaecology

Q 1: Please rate your overall satisfaction with the format of the course:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 2: Please rate course notes:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 3: The lecture sequence was well planned

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 4: The lectures were clear and easy to understand

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 5: Please rate the quality of pre-course administration and information:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 6: Any other suggestions:

Comments:

Thank you for taking the time to complete this survey, your comments are much appreciated.

***OPTIONAL Section*:** Name _____
Signature _____ Date _____

Annexure 4

Course/Training Feedback Form

Course: LABOUR WARD DRILLS
Date: 25/08/2019
Name: MERLIN, S
Reg NO. U16MB326
Department: Obstetrics and Gynaecology

Q 1: Please rate your overall satisfaction with the format of the course:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 2: Please rate course notes:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 3: The lecture sequence was well planned

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 4: The lectures were clear and easy to understand

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 5: Please rate the quality of pre-course administration and information:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 6: Any other suggestions: NILL

Comments:

Thank you for taking the time to complete this survey, your comments are much appreciated.

***OPTIONAL Section*:** Name _____
Signature _____ Date _____

Annexure 4

Course/Training Feedback Form

Course: LABOUR WARD DRILLS
Date: 24/01/2020
Name: KAVIYA. K
Reg NO. U16MB312
Department: Obstetrics and Gynaecology

Q 1: Please rate your overall satisfaction with the format of the course:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 2: Please rate course notes:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 3: The lecture sequence was well planned

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 4: The lectures were clear and easy to understand

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 5: Please rate the quality of pre-course administration and information:

a. Excellent b. Very Good c. Satisfactory d. unsatisfactory

Q 6: Any other suggestions: NILL

Comments:

Thank you for taking the time to complete this survey, your comments are much appreciated.

***OPTIONAL Section*:** Name _____
Signature _____ Date _____

Date: 24..06.2019

From
Dr. K.DURGA
Assistant Professor,
Obstetrics and Gynaecology,
Sri Lakshmi Narayana institute of Medical sciences,
Bharath Institute of Higher Education and Research,
Chennai.

Through Proper Channel

To
The Dean,
Sri Lakshmi Narayana institute of Medical Sciences,
Bharath Institute of Higher Education and Research,
Chennai.

Sub: Completion of value-added course: Labour Ward Drills

Dear Sir,

With reference to the subject mentioned above, the department has conducted the value-added course titled: **Labour Ward Drills** on JAN 2019- JUN2019. We solicit your kind action to send certificates for the participants, that is attached with this letter. Also, I am attaching the photographs captured during the conduct of the course.

Kind Regards

Dr.DURGA

ASSOCIATE PROFESSOR
DEPT. OF OBSTETRICS & GYNAECOLOGY
Sri Lakshmi Narayana Institute of
Medical Sciences
OSUDU, PUDUCHERRY.

VALUE ADDED COURSES

OBGY 10 LABOUR WARD DRILLS