

Perinatal Forms Guideline 4

LABOUR ADMISSION AND PARTOGRAM (HLTH 1583)

INTRODUCTION

The Labour Admission and Partogram (2002/2003) is a combination of the old Nursing Admission Record and Partogram. The combined form prevents unnecessary duplicate charting. Information regarding past obstetrical history, medical/surgical history, and history of the current pregnancy will be obtained from the Antenatal Record. There is a stronger emphasis on “normal” labour and the area for narrative notes has been considerably expanded. This guideline provides guidance for completion of this form and also provides specific guidance for narrative charting of fetal heart surveillance during labour.

If any clarification is required under “Elements to Collect,” then please refer to: Forms Guideline 11: Abbreviations used in the Provincial Perinatal Forms.

GENERAL OVERVIEW

- I. The Labour Admission and Partogram form is designed to organize units of information in a chronological flow during labour and birth.
- II. This form is to be initiated on all patients in established labour. Established labour is defined as the presence of contractions resulting in cervical effacement and dilation. Established labour is expected to progress at approximately 1 cm per hour.
- III. This form is to be used for all induction and augmentation routines.
- IV. When more than one Labour Admission and Partogram is required, the time in Section 2 will be continuous.
- V. In Section 3, Baseline Fetal Heart Rate indicates the type of fetal heart surveillance (auscultation, external or internal monitoring), and the fetal heart rate baseline. In addition to a documented baseline, fetal heart assessment should be documented as reassuring or non reassuring. Criteria indicating reassuring findings are included for guidance. Non reassuring fetal assessment requires a documented narrative note.

SECTION I: ADMISSION INFORMATION

Complete this section checking boxes and completing information as indicated. If data is not relevant to a patient, indicate N/A. The admission fetal heart should be recorded in Section 2. Stamp the right upper section with the patient’s addressograph.

Elements to Collect:

- *Date*
- *Time*
- *Reason*
- *Antenatal Form Reviewed: Not Available, Yes*
- *EDD*

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- Gest. Age
- G, T, P, A, L
- Blood Group/Rh Factor

Abdominal Palpation:

- Fundal Height, cms
- Lie
- Presentation
- Position
- Engagement
- Fetal Activity: Normal, Increased, Decreased

Contractions Began:

- Date, Time
- Regular Q, Mins. Since Date, Time

Membranes Ruptured:

- No, Yes, Queried, Date, Time
- Nitrazine Test: (if applicable), Pos, Neg, Equivocal
- Ferning Test: (if applicable), Pos, Neg
- Amniotic Fluid: Clear, Bloody, Meconium, Thin/Staining, Thick, Particulate
- Bishop Score at Induction
- Height
- Current Weight

Previous Admissions:

- No, Yes, Reason
- NST: No, Yes
- Ultrasound: No, Yes

Recent Infectious Disease Contact (e.g. Chicken pox)

- No, Yes (specify), Date
- HSV: No, Yes, Date of last lesion
- GBS Screen: No, Yes, Result, Not Known

Prenatal Education:

- No, Yes, Previous Pregnancy
- Pregnancy Outreach Program: No, Yes

Birthplan/Requests:

- No, Yes, (specify)
- Breastfeeding: No, Yes
- Planned VBAC: No, Yes
- Support Person(s)

Allergies:

- None Known, Yes (specify)
- Current Medications/Complementary Therapies
- Identify Problems/Concerns Expressed
- RM/MD
- Notified at: Hrs., By:

SECTION 2: FIRST STAGE TIMELINE

This section indicates the timeframe. There are 12 one-hour boxes divided into 15 minute intervals. Begin the first box at the hour in which the patient is admitted. For instance, if admission time is 0915, then label the first hour 0900 and chart the fetal heart in the second small box to the right, which would stand for 0915.

SECTION 3: FETAL HEART RATE (FHR)

This section indicates baseline fetal heart rate. Chart according to the coding system: “O” for auscultation, “X” for external fetal monitoring, “M” for internal fetal monitoring. In addition to a documented baseline, fetal heart assessment should be documented as reassuring or non reassuring. Criteria indicating reassuring findings have been included for guidance.

Nonreassuring fetal assessment continues to require a documented narrative note.

Note: Until evidence is available supporting the benefits of admission cardiotocography on neonatal outcome, the BCRCP does not recommend the use of admission EFM tracings on admission of healthy, term women in labour with an absence of risk factors for adverse perinatal outcome. (See Obstetric Guideline 6B: Electronic Fetal Monitoring in Labour, Scalp Sampling, and Cord Gases).

I. AUSCULTATION

- Document the rate with a “O” in Section 3
- Provide narrative charting for Non-Reassuring FHR
 - Baseline FHR > 160 bpm
 - Baseline FHR < 110 bpm
 - Presence of decelerations:
 - i. Indicate if they are gradual or abrupt
 - Lack of accelerations with obvious fetal movement
 - Technically inaudible fetal heart
 - Document:
 - i. Uterine activity during non-reassuring findings
 - ii. Specific actions taken when fetal heart changes occurred
 - iii. Fetal responses to your nursing interventions
 - iv. Communication with the primary care giver

II. EXTERNAL OR INTERNAL ELECTRONIC FETAL MONITORING

Transposing key data and major changes in maternal/fetal conditions from the fetal heart strip to the Labour Admission and Partogram will likely be required when using electronic fetal monitoring. Charting on the fetal monitoring strip is convenient when decisions are being made rapidly, and fetal heart changes in response to changes in maternal status or medical/nursing interventions can easily be observed. Although the fetal heart strip is a legal part of the patient’s chart there is always the risk that it may go missing, in which case documentation of all positive actions provided by the caregiver could be lost. There are some specific issues to consider when

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transposing information from the fetal heart strip to the Labour and Admission Partogram. They include:

- A. Ensure that the clock used for timing events is consistent. The wall clock and the time on the monitor are usually different. Ideally, the times would be synchronized. If charting on the strip at first instance, then use the time on the strip as the time transferred to the chart. Problems can arise when charting is done on the strip (and those times are transposed to the chart), but when the baby is born, the wall clock is used. This potentially creates confusion about the time of birth.
- B. Ensure that information transposed from the fetal heart strip to the chart is consistent so that misrecordings on the Labour and Admission Partogram are avoided.

Specific Documentation guidelines for electronic fetal monitoring include:

- Document the rate with a “X” or “M” in Section 3
- Provide narrative charting when external or internal electronic fetal monitoring is used.
Document:
 - The indication for initiating electronic fetal monitoring
 - Baseline variability in amplitude and cycles per minute, the presence or absence of accelerations, the presence and type of decelerations, and the uterine activity
 - Document whether the tracing is reassuring or non-reassuring
 - For non-reassuring fetal heart strips, document:
 - i. Specific actions taken when fetal heart changes occurred
 - ii. Fetal responses to your nursing interventions
 - iii. Communication with the primary care giver
- Charting on the fetal heart strip may include:
 - Patient Information
 - i. Addressograph
 - ii. Fetal heart strip #
 - Maternal Clinical Information
 - i. Abnormal Maternal vital signs
 - ii. Position and position changes
 - iii. Medications that may effect fetal status
 - iv. PV loss – blood, meconium
 - v. Significant changes in maternal condition
 - Nursing Interventions
 - i. Nursing Interventions for intrauterine resuscitation
 - IV initiation or rate increase
 - Position changes
 - O2 per mask
 - VE exam results
 - ii. Oxytocin adjustments
 - Medical Interventions
 - i. Epidural insertion and top-ups
 - ii. Forceps/Vacuum application

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Elements to Collect:

- *R (reassuring) = Baseline rate 110 – 160 bpm, Accelerations (if present), Lack of decelerations, (if EFM) Variability ≥ 6 bpm ≤ 25 bpm*
- *NR = non reassuring*

SECTION 4: MATERNAL VITAL SIGNS

There is a separate graph for maternal vital sign documentation.

Elements to Collect:

- *temperature, pulse, blood pressure*

SECTION 5: VAGINAL EXAMS

- Record cervical dilation in centimeters with an “X”
- Record station of presenting part with an “O”
- Comment section allows for recording of position, consistency, and effacement of the cervix; presentation, position or moulding of the presenting part
- Record initials of person performing the exam
- Indicate PV bleeding, show, amniotic fluid, and results of urine testing

Elements to Collect:

- *Position of Cervix*
- *Consistency*
- *Effacement/Length*
- *Presentation/Position*
- *Moulding/Caput*
- *Examiner*
- *Bleeding/Show*
- *Amniotic Fluid*
- *Urine Protein*
- *Ketones*

SECTION 6: CONTRACTIONS

- Record the frequency as either number of contractions occurring during a 10 minute period or q “X” minutes (as per hospital policy)
- Record strength as mild, moderate, or strong
- Record duration of contraction in seconds

Elements to Collect:

- *Frequency*
- *Strength*
- *Duration*

SECTION 7: COMFORT MEASURES/TREATMENTS

Record all comfort measures offered during labour. A variety of comfort measures should be implemented during labour. Comfort measures are important to document and hence space is provided for documentation of ongoing supportive measures. This section is not meant to provide sufficient space for narrative charting.

SECTION 8: MEDICATIONS

Record all medications administered including induction/augmentation agents, tocolytics, or analgesia. The section identified as “Other” is for medication (other than oxytocin) that is titrated.

There is a separate section for analgesia.

Elements to Collect:

- *Oxytocin mu/min*
- *Other*
- *Analgesia*

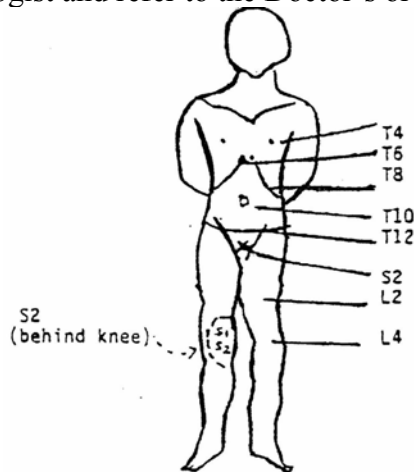
SECTION 9: EPIDURAL AND INITIALS

- Indicate the type of epidural – intermittent, continuous, ambulatory, patient controlled analgesia (PCA) or combined spinal epidural (CSE)
- Indicate the analgesia infusion rate
- Indicate the sensory level

The method and frequency of assessing the sensory level should be clearly stated in the hospital policy on epidurals. The hospital policy should also indicate nursing responsibilities if the sensory level becomes too high. Sensory levels at T9/10 are optimal, but T8 is acceptable. (See diagram below).

Sensory Level Testing

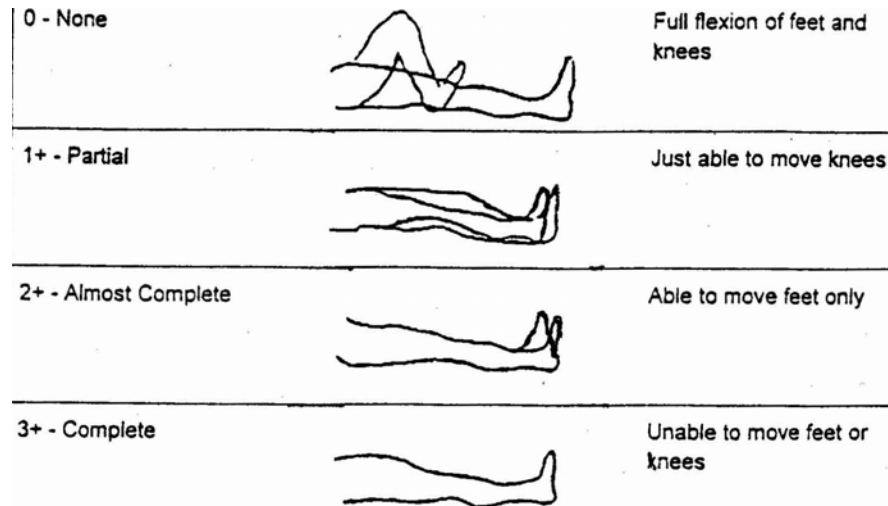
- T9/10 Optimal Level
- T8 Acceptable
- T6 Notify anesthesiologist and refer to the Doctor’s orders



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- Indicate the degree of motor block.

The method and frequency of assessing the degree of motor block should be clearly stated in the hospital policy on epidurals. The hospital policy should also indicate nursing responsibilities if the motor block becomes excessive. Motor blocks at 0 to 1+ are ideal. (See diagram below)



- Indicate the effectiveness of the epidural. Indicate Effective, Moderately Effective, or Ineffective. If ineffective, narrative notes should be made re: further description and consultation.
- Every assessment should be initialed and the initials should be documented on the hospital signature record.

Elements to Collect:

- Intermittent, Continuous, Ambulatory, PCEA, CSE (may check more than one)
- Rate
- Sensory Level
- Motor Block
- Effective
- Initials

NOTES FOR FIRST AND SECOND STAGE

Any narrative charting during first or second stage of labour should be completed in this section. It is expected that narrative notes continue in 2nd stage of labour. Should a longer narrative section be required then use of nurse's notes or interprofessional notes will be required.

SECTION 10: SECOND STAGE

- Complete the time that cervix is fully dilated and the time that active pushing begins (these two times are often different)
- Indicate the type of fetal surveillance done in second stage of labour
- Record the fetal heart rate at least every 5 minutes
- Indicate time of birth and time that placenta delivers

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Elements to Collect: Section 10

- *Cervix Fully Dilated at*
- *Active Second Stage Commenced at*
- *Fetal Heart Rate as Least Q 5 mins. (Active 2nd Stage), AUSC, EFM, IFM*
- *Time of birth and time Placenta delivered*

SECTION 11: THIRD/FOURTH STAGE

There are two options for charting during the fourth stage of labour.

- Continue charting on the Partogram in Section 11 until the mother and baby are transferred to the postpartum unit or discharged home
- Initiate charting on the Maternal Postpartum Care Path (Vaginal Delivery)
- If mother and baby are discharged home, complete the Community Liaison Record: HLTH 1591

Elements to Collect:

- *To Postpartum Care Path (if applicable)*
- *Breast Feeding Initiated*
- *Baby to SCN/NCN, Time, Indication*
- *Time*
- *BP*
- *Pulse*
- *Temp.*
- *Fundus*
- *Flow*
- *Perineum*
- *Medications/Notes*
- *Mother/Baby Transferred: No, Yes, Time, To*
- *Discharged from LDR: No, Yes, Time*
- *Community Health Nurse Notified: No, Yes*

REFERENCES

Society of Obstetricians and Gynaecologists of Canada. 2002. Fetal Health Surveillance in Labour. No.112, March.

Society of Obstetricians and Gynaecologists of Canada. 1995. Fetal Health Surveillance in Labour. Journal SOGC. September, p.856-901.