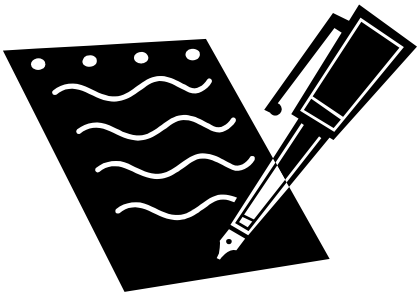
CHAMPLAIN MATERNAL NEWBORN REGIONAL PROGRAM
PROGRAMME RÉGIONAL DES SOINS À LA MÈRE
ET AU NOUVEAU-NÉ DE CHAMPLAIN

Intrapartum Documentation Guidelines



A collaborative project by
CMNRP's Regional Intrapartum Documentation Tool Working Group

2013

Original Members of PPPESO's Perinatal Advisory Committee Documentation Working Group (2005)

Norene Allan	Nurse Manager, Obs	Perth & Smiths Falls District Hosp.
Melinda Black	Team Leader, Birth Unit	Queensway-Carleton Hospital
Janet Brownlee	Nurse Educator, Birthing Unit	TOH – General Campus
Peggy Edwards	Staff Nurse, Maternal/Child	Cornwall Community Hospital
Susan Jewell	Clinical Instructor - Maternity/Kidd Davies	Kingston General Hospital
Leanna Lefebvre	Staff Nurse, Maternal/Child	Cornwall Community Hospital
Linda McCabe	Nurse Educator, Birthing Unit	TOH – Civic Campus
Lucy Pagnier	Clinical Educator, Birth Unit	Queensway-Carleton Hospital
Liz Reid	Team Leader, Maternal/Child	Quinte Healthcare, Belleville
Rachel Rieux	Staff Nurse, Birth Unit	Hôpital Montfort
Karen Schreader	Clinical Director - Maternal/Child	Pembroke General Hospital
Carol Thomas	Staff Nurse, Birthing Unit	TOH – General Campus
Marie-Josée Trépanier	Perinatal Coordinator	PPPESO
Janet Whalen	Manager, Maternal/Child	Quinte Healthcare, Belleville

Members of CMNRP's Regional Intrapartum Documentation Tools Working Group (2013)

Dr. Nika Alavi	OBS Resident	TOH
Gerry Ashton	Nurse Educator, Birthing Unit	TOH – General Campus
Lynn Campbell	Nurse Manager – OBS Coordinator	Renfrew Victoria Hospital
Dr. Jessica Dy	Obstetrician	TOH – Civic Campus
Sandra Gervais	Midwife	Ottawa South Midwives
Linda McCabe	Nurse Educator, Birthing Unit	TOH – Civic Campus
France Morin	Perinatal Consultant (Chair)	CMNRP
Kemi Ogundipe-Micho	Director Maternal/Child	Cornwall Community Hospital
Cathy Ottenhof	BORN Coordinator	BORN Ontario
Karen Schreader	Clinical Manager	Pembroke Regional Hospital
Jennifer Torode	Director Maternal-Child Program	Brockville General Hospital
Paisley Twigge	Team Leader	Almonte General Hospital
Kathy Williamson	Staff Nurse	TOH – Civic Campus

The forms have been designed by **Marie-Reine Charron** from the Printing Department at The Ottawa Hospital, General Campus

INTRAPARTUM DOCUMENTATION GUIDELINES

The *Intrapartum Documentation Tools* were originally developed in 2005 by a working group of the Perinatal Partnership Program of Eastern & Southeastern Ontario (PPPESO) in an effort to improve and standardize multi-disciplinary documentation of intrapartum events throughout the region. Having recognized the need to have more consistent and complete documentation and to improve communication between health care providers during the intrapartum period, several representatives from our partner hospitals worked together to develop these documentations tools. In 2012-2013, the tools have been revised by CMNRP's Regional Intrapartum Documentation working group.

Guiding principles were used throughout the design and revision process to ensure the tool would be:

- Usable on a variety of settings, from pre-admission and through labour and birth
- Used by all care providers (multi-disciplinary)
- Adaptable for different levels of care
- Adopting standard approved terminology and abbreviations
- Preventing or eliminating double-charting
- User-friendly and efficient (use of « tick-off » boxes and abbreviations where possible)
- Minimizing need for narrative notes
- Facilitating data collection and data entry of variables in the BORN Information System (*formerly known as* the Niday Perinatal Database) and hospitals' information systems
- Meeting institutions' standards for charting/health records
- Adaptable for charting-by-exception format
- Integrated into clinical pathway process where possible
- Aimed at risk-reduction
- Available in both languages, for bilingual hospitals

The tool's format and design offers the following *characteristics*:

- Copyright CMNRP to acknowledge the partnership work.
- The tools can be customized with individual hospital logos, and ordered centrally through the Printing Department of The Ottawa Hospital.
- The forms are available in either the bilingual version, French-only version or the English-only version.
- All sections of the tool can be used by ALL health care providers: physicians, midwives and nurses.
- All variables from the *BORN Information System* are included within the tools, ensuring easier retrieval for data entry.
- Events are documented in a chronological order, with minimal use of different separate forms.
- A flowsheet containing the majority of intrapartum assessments and interventions minimizes charting duplication and the need for narrative notes.
- Contemporaneous recording at the woman's bedside is encouraged.

GENERAL DESCRIPTION OF DOCUMENTATION TOOLS

OBS 93-A PATIENT HISTORY	• Four-page form to identify key information from the woman's obstetrical and medical history (includes a general Birth Plan) • The majority of this form is to be completed by the woman herself (if possible); the partner or other support person can also enter the woman's responses**.** The first portion of the form is to be completed by a health care provider (Physician/Midwife/Nurse) upon admission. • It summarizes key socio-cultural information and complements the Ontario Antenatal Record. • Space at the bottom of last page is provided for patient's and reviewing nurse's signature. • This form can be used at all entry points: pre-admission clinic, triage, or direct admission. If the woman returns home after initial visit, the form is to be kept with the patient's Ontario Antenatal Record, to be consulted again at subsequent visits.
OBS 93-B OBSTETRICAL ASSESSMENT / TRIAGE RECORD	• Two-page, multi-copy form. • It allows quick documentation of key assessments and interventions while prioritizing care. • A legend is provided at the back of the first page. • Integrated Progress Notes (for multi-disciplinary use) provided for narrative notes. Space is provided at the bottom of the second page for names and signatures of all recorders. • This form is to be used every time a woman presents at Triage / Obstetrical Assessment Unit (or in the Birth Unit if there is no separate triage area).
OBS 93-C LABOUR FLOWSHEET	<u>12-page booklet, containing</u>:
Admission *(Cover page)*	• This page is only completed when the woman is admitted for labour and birth, or transferred from another institution. A summary of key history data, fall risk assessment and current pregnancy/labour status are included on this page. There are two signature sections at the bottom of the page for health care providers using the booklet. The "Assigned Nurse/Midwife" section is specifically formatted to facilitate documentation of the nursing transfer of accountability as per individual institutional practice.
Vital Signs/Progress of Labour Record *(Pages 2-7)*	• This graphic flowsheet allows for quick charting of key fetal and maternal assessments (fetal health surveillance and uterine activity characteristics, vital signs, etc.), supportive care activities, common interventions, teaching and fall risk interventions. The six pages allow for a minimum of 24 hours of charting.
Intake & Output *(Page 8)*	• Record used to document oral and IV intakes, urinary output and testing, and other outputs. • Space provided at bottom of the page to record IV and saline locks, and indwelling urinary catheter insertion.
Medication Administration Record *(Page 9)*	• All medications administered are to be documented here, including once-only, PRN, STAT, pre-op and regular medications. • Space provided at the bottom of the page to document repeat lab tests and additional investigations.
Partogram *(Page 10)*	• The Partogram can be used each time a vaginal examination is performed. Charting of membranes status, amniotic fluid characteristics, show, bleeding, pushing status and cervical ripening agents can be done here. • A legend is provided at the bottom of the page for the documentation of key variables.
Active Second Stage *(Page 11)*	• Record used to document key assessments and interventions during the active second stage (once pushing has begun). Times of key events and communications are also recorded here. • It permits the documentation of approximately 2.5 hours of q 5-min assessments. • A section is also provided for the count of instruments, needles and sponges.
Legend *(Back page)*	• Legend for all key assessments and interventions recorded on the flowsheet.

GENERAL DESCRIPTION OF DOCUMENTATION TOOLS – Cont'd

OBS 93-G REGIONAL / PCA ANALGESIA RECORD	• One-page form specifically designed to facilitate documentation during those analgesia/anesthesia procedures requiring special pump infusion management: epidural or spinal via continuous infusion or PCA. • Times of key events and communications related to analgesia management are also recorded here. • A legend is provided for key variables at the bottom of the page.
OBS 93-D BIRTH RECORD	• Two-page, multi-copy form. • First page summarizes key information from the woman's history as well as labour interventions/events. • Second stage summarizes key birth and early postpartum interventions/events.
OBS 93-F INDUCTION REQUEST	• One-page form to be used by physicians and midwives who request induction. • Includes induction priority, indications, planned method and comment/follow-up.

DETAILED DESCRIPTION OF EACH DOCUMENTATION TOOL

PATIENT HISTORY (OBS 93-A)

HOW & WHEN TO USE?

To be completed by the woman herself ideally (or by the partner or other support person) during initial visit to pre-admission clinic, triage or direct admission, then reviewed and updated as needed at each subsequent visit to the Birth Unit.

CONTENTS:

General History	• Overall health status • Medications during pregnancy • Maternal smoking – Specify whether smoking maintained before and/or after 14 weeks gestation, and whether exposed to second-hand smoke • Alcohol and recreational drugs – Indicate average amount and specify other details as required
Family and Lifestyle Factors	• History of life stresses, losses, mental health problems • Parenting concerns • Support available • Feelings about pregnancy
Birth Plan	• Intention to breastfeed or bottle-feed and past history of breastfeeding • Priorities for labour and birth/caesarean birth • Choice of comfort measures for pain relief • Preparation for birth
Completed and Reviewed by	• Signature of the patient • Signature of RN who reviewed the form after completion (should be completed and reviewed during history-taking process)

OBSTETRICAL ASSESSMENT / TRIAGE RECORD (OBS 93-B)

HOW & WHEN TO USE?

- Separate form to be used at each visit to Triage Unit, or as part of initial assessment prior to admission.
- Keep in patient's chart with Ontario Antenatal Record.

CONTENTS:

PAGE 1	
General Information	• Date & time of patient's arrival in OAU/Triage; name of primary care provider • Gestation information, maternal weight • Indicate reason(s) for visit (check as many as apply); specify as needed • Indicate where patient referred from for assessment (home, care provider's office, clinic or other)
Group-B Strep & Allergies	• Indicate screening results for Group-B Strep (from Ontario antenatal Record or other source) • Specify allergies and adverse reactions
Previous visit to OAU this pregnancy	• Check if patient was previously seen in OAU/Triage this pregnancy. If yes, specify number of previous visits • Review and update as needed the Patient History Record which has been completed previously
Priority Code	• See legend on back of form to determine urgency for assessment and care
Significant History Information	• Indicate presence of pregnancy complications • Pertinent medical history *(refer to Ontario Antenatal Record)*
WOMAN ABUSE (WA) *(not spelled out to minimize suspicion from partner or other support, should they see the form)*	• Women are asked about abuse at every visit. Screening is done in the context of a health history, in a private location with only the woman and nurse present. If translation is required, a professional translator is used, not a family member. *Legend for patient's responses:* D = Disclosure (woman responds Yes when asked about abuse) ND = Non-disclosure (woman says No or does not respond when asked about abuse) NA = Not able to ask Other * = Other details noted in narrative notes (NN). NOTE: When woman is asked and she answers No, but indicators are present, the HCP is to prompt by mentioning specific indicators that are present and give general information about abuse. If no disclosure is still made, then document response and indicators that are suspect/present. REFERENCES: PPPESO (2004)*Guidelines for Health Care Providers - Woman Abuse During the Perinatal Period* RNAO's Best Practice Guideline - *Woman Abuse: Screening, Identification and Initial Response*
Medications	• List medications used during pregnancy
Ontario Antenatal Record Review	OAR = Ontario Antenatal Record, Parts 1 & 2 • Indicate when each part of the OAR has been reviewed (or check-off "Unavailable")

OBSTETRICAL ASSESSMENT / TRIAGE RECORD (OBS 93-B) – Cont'd

Maternal and Fetal Assessment Flowsheet	• FHR & Uterine Activity: Spaces for 5 assessments while in OAU/Triage • Maternal Status: Spaces for 4 assessments • Vaginal Exams: Spaces for 2 sets of vaginal examination findings, if performed • See legend on back of form for abbreviations and symbols
Tests	• Indicate all tests done while in triage, and results: Non-Stress Test (NST), Amniotic Fluid (AF), urine testing, and other tests as needed
Care Provider Notification	• Indicate the name of the Care Provider notified of patient's visit to OAU/Triage, and time of notification
Physician's Orders	• Indicate date and time physician orders received (verbal and written), signature, then time of order completion and initials
Admission, Discharge and Transfer	• If admitted from triage, indicate time and destination • If discharged or transferred from triage, indicate time, destination, as well as teaching done prior to discharge
Signatures & Initials	• Printed name, signature and initials of care providers while in OAU/Triage

REVERSE OF P. 1 LEGEND	• Legend for Priority Codes and other assessment variables

PAGE 2 INTEGRATED PROGRESS NOTES	• Narrative notes to provide additional details about assessments, interventions and communications are documented • Form designed for multi-disciplinary use
SIGNATURE SECTION	• Space at bottom for names, signatures and initials of health professionals who care for the woman in OAU/Triage

LABOUR FLOWSHEET (OBS 93-C)

HOW & WHEN TO USE?

- Start using booklet when woman is admitted for labour and birth.
- Space provided for charting common assessments and interventions for a minimum of 24 hours.
- Narrative notes (NN) are to be documented on separate hospital-approved document forms.

CONTENTS:

ADMISSION RECORD *(page 1 of 12)*

NOTE: *During the Admission interview, please review the Antenatal Record and Maternal Health History Patient Questionnaire. These contain other history, transfer information, and BORN Database variables. As well, initiate the Birth Record.*

Medication Reconciliation	• Complete as per hospital policy
Admission Information	• State where patient is admitted from: home, HCP office, clinic, other - This means location prior to OBS Assessment Unit (Triage) visit • Record Information source (patient, partner, other HCP, etc) • Reason for admission: Write out primary reason(s). Please note: Transfer information is documented on the top portion of the Birth Record.
General Information	• Languages: Indicate languages spoken. • Gestation history and EDB • Name and contact information of partner or other support person(s) • Specify any requested visiting restrictions. • Allergies and reactions: Specify and indicate whether allergy bracelet has been applied.
Pertinent Medical History	• Specify any pertinent medical history identified by the woman, the Ontario Antenatal Record, Maternal Health History Patient Questionnaire and other available documents/chart(s)
Woman Abuse	WA = Woman Abuse *(not spelled out to minimize suspicion from partner or other support, should they see the form)* • Question about abuse must be asked at every visit. Ensure that the woman is asked this question privately (when alone with her, or while accompanying her to bathroom) • Please refer to *Guidelines for Health Care Providers - Woman Abuse During the Perinatal Period* for different ways to ask about abuse, depending on circumstances *Legend for patient's responses:* D = Disclosure (if she answers Yes) ND = Non-disclosure (if she answers No) NA = Not available (if she wishes to not answer) Other * = Other details noted in narrative notes (NN). Includes CAS/social work alerts.
Fall Risk Assessment	All patients are assessed as to their level of risk for falls on admission, if their condition changes (e.g. epidural or 4th stage), and at the beginning of each shift. Research shows that impaired mobility and fall within last 3 months are the greatest predictors of risk for falls. • Someone who normally mobilizes using an assistive device (eg. wheelchair) is not at increased risk unless there is a change in her condition. • Sensory deficits including impaired vision and hearing can be included under "Other", if they have the potential to affect her fall risk. Additional information can be written in "Comments". • Indicate risk assessment: No or Yes. If yes, document in NN if additional explanation required. Eg. *Other: Needs glasses to see* *Comments: Glasses available.* *At Risk: No* *See notes: No additional notes required* • Indicate Fall Safety Interventions. All patients require Universal and some may require both Universal and individualized.

Universal Fall Safety Interventions (select for ALL patients)	• Review the fall history every shift, prn • Bed at lowest appropriate height • Mobility/assistive devices/telephone/call bell within reach • Proper footwear • Wipe up spills/maintain clear paths • Use clear concise communication/education strategies
Individualized Fall Safety Interventions (select for patients identified as being AT RISK for a fall)	• Supervision and/or assistance with mobility • Epidural/spinal: ability to ambulate as per protocol • First postpartum ambulation/shower: vital signs/postpartum assessments normal; nourishment; shower chair; assistance with toileting & in/out of shower • Document in NN any additional individualized interventions
Height and Weight	• Indicate woman's usual and current weights, height and pre-pregnancy BMI
Ontario Antenatal Record (OAR 1 & 2) Maternal Health History	• Indicate records have been reviewed or are unavailable.
Current pregnancy information	• Gestation information: G- Gravida; T – Term; P – Preterm; A – Abortion; L- Living at this time • EDB: Expected date of birth; Gest–Current gestational age. Verify with gestational calendar prn. • Strep-B status: write as pos, neg or unk (unknown). • Labour onset – active labour if applicable • Membranes and amniotic fluid status at admission • Problems with this pregnancy - identified by the woman, Maternal Health History, the Ontario Antenatal Record and other available documents/chart • Indicate date when steroids have been administered for preterm labour, if applicable
Other Admission Information	• Indicate problems with previous births - identified by the woman, Maternal Health History, the Ontario Antenatal Record and other available documents/chart • Check box when woman/family oriented to unit • Infection Prevention and control precautions initiated. Document specific precautions prn.
Comments	• Indicate significant findings from Ontario Antenatal Record, Maternal Health History, special alerts or other pertinent information related to the woman's admission and care.
Assigned Signature Section	• Name and signature of the assigned nurse(s)/midwife(s), clinical time frame of care, Transfer of Accountability (NTA) completion, and patient agreement to bedside NTA.
Relief Signature Section	• Names, signatures, and initials of <u>all</u> health care providers who are charting in the booklet throughout labour and birth.

MATERNAL/FETAL ASSESSMENTS – utilize until active pushing or OR *(pages 2-7)*

Date and Time	• Indicate date and time of regular assessments/interventions. • Date is recorded in the box under the header "Date". • Time: - Continuous electronic fetal monitoring (EFM): – The hour would be documented in the top box, for example, "1000" and smaller boxes underneath could indicate "00 15 30 45". In this example, the FHS assessment involves the previous 15 minute period. – Each column can be sequentially used for charting, whether at regular 15-minute intervals or patient specific intervals, indicating the exact time of the assessment (eg. 10:43). In this example, the FHS assessment involves the interval between previous and current entries. – Individual institutions' policies and preferences will dictate which charting method is used. - Auscultation: use the exact time of the assessment. Please note: The 6 pages provide enough space for a minimum of 24 hours of charting at q15-minute intervals.
FETAL ASSESSMENT	• Use legend on p. 12 for abbreviations and symbols. • Indicate "✔" if scalp stimulation performed • For institutions performing scalp pH, indicate result if scalp blood sampling obtained.
UTERINE ACTIVITY	• Use legend on p. 12 for abbreviations.
IV - Intravenous Medications	• Indicate name of IV medication being administered (lines for up to 3 medications provided; Oxytocin is preset; use blank spaces for other IV medication). A blank line may be used for documentation of time of specific dosage changes as per institution practice. • Note "D/C" in appropriate column if discontinued (include details on Intake & Output Record, p.8, and on Medication Administration Record, p.9)
MATERNAL ASSESSMENT Maternal Vital Signs	• Document according to institutional practices and clinical indications. • Use graph to indicate maternal pulse "●" and blood pressure "⋁ " (systolic), "⋀" (diastolic). • Arterial Lines: – Art Line BP - write as a number at top of VS graph – NIBP (cuff) - use the symbols to chart the BP. Do not write numbers for NIBP • Use spaces under graph to chart temperature and respiration. • Document oxygen saturation if pulse oximetry used.
Arterial Line	• Use if arterial line present as per legend on p. 12.
Breath Sounds Reflexes	• Breath sounds are to be documented if clinically indicated (eg. asthma, patient with pre-eclampsia on magnesium sulphate) • Chart other maternal assessments, as required (eg. reflexes)
Pain Scale	• Ask woman to evaluate her pain, using a scale of 0 (indicating no pain) to 10 (indicating the worst possible pain).
Vaginal Exam	• Indicate with a check mark "✔" each time a vaginal exam is performed. This provides quick visual cues about frequency of assessments. Document vaginal exam findings on the Partogram, p.10 and in the NN if more detailed documentation required.
Emotional Status	• Indicate the woman's emotional status, as per legend on p. 12.
SUPPORTIVE CARE	• Use legend on p. 12 for abbreviations to document common supportive care activities. • Use NN as required.
INTERVENTIONS	• Indicate interventions performed to correct atypical or abnormal FHS assessment data: – Position change: Use legend on p. 12 for abbreviations. – Fluid Bolus: Indicate amount in mL. Please note: this volume is included in the intake and output calculations. – Oxygen by facemask at 8-10 L/min or nasal prongs at 3-6 L/min. • Indicate "✔" when primary or other care provider notified of clinical situation, and add details of

	communication in NN. Please note: If same intervention continuing, insert arrow → in subsequent boxes to indicate this.
Fall Risk	• See legend on p. 12 for factors that increase risk of falls. • Use "✓" (Low Risk) or "+" (Increased Risk) as per legend. • Document either "U" for Universal or if at risk, "U/I" for Universal and Individualized interventions. • Document additional information in NN.
Universal Fall Safety Interventions (select for ALL patients)	• Review the fall history every shift, prn. • Bed at lowest appropriate height. • Mobility/assistive devices/telephone/call bell within reach. • Proper footwear • Wipe up spills/maintain clear paths. • Use clear concise communication/education strategies.
Individualized Fall Safety Interventions (select for patients identified as being AT RISK for a fall)	• Supervision and/or assistance with mobility • Epidural/spinal: ability to ambulate as per protocol • First postpartum ambulation/shower: vital signs/postpartum assessments normal; nourishment; shower chair; assistance with toileting & in/out of shower • Document in NN any additional individualized interventions
Hourly Rounding	• Use "✓" when completed according to institutional practices.
Nurse's initials	• Nurse to put initials in bottom row when charting done in column. Ensure name is printed and signed on front page as appropriate.

*NOTE: Insert an asterisk * in any space when further details about particular assessments or interventions have been charted in the narrative notes.*

LABOUR FLOWSHEET (OBS 93-C) – Cont'd

INTAKE / OUTPUT RECORD *(page 8 of 12)*

INTAKE	• Date and times of initiation of IV infusions • Indicate oral intakes (PO) if strict monitoring of In & Out required. • Name of I.V. solutions (6 spaces provided) • Total amounts absorbed
OUTPUT	• Urine: Mode – Use legend at bottom of page for abbreviations. Quantity in mL • If dipstick done, document findings for Protein, Ketones & Blood. • Enter other outputs, as necessary • Total amounts excreted
INITIALS	• Initial when completing shift totals using the "Initial" column. Please note: Initialling each entry is not required.
24 HOUR TOTALS	• Complete for complex patients at the end of each 24 hour period. • A positive balance is indicated with a "+" sign. Please note: If the patient's intake is more than her output, she is in a positive balance.

SALINE LOCK/ IV /BLOOD PRODUCTS/SITES	• Date and time of IV or Saline lock insertion (spaces provided for initiation of IVs or saline locks) • Indicate gauge used, number of attempts, use of buffered lidocaine, saline lock, and insertion site. • Document names of IV solution/blood product, infusion volume. If additional space is required, document under the Once only/STAT/Pre-op Medication Administration Record (MAR) on p. 9. • Initial each entry.
INDWELLING CATHETER INSERTION	• Indicate size of Foley catheter (# FR). • Initial of person inserting catheter. • Document date and time.

MEDICATION ADMINISTRATION RECORD (MAR) *(page 9 of 12)*

General	• The MAR is divided into 2 separate MARS: 1. Once Only / STAT / Pre-op 2. Regular / PRN Medications • Medications are transcribed to appropriate section at time of initial administration. • The RN transcribing the Regular and PRN orders will write her initials in the "INIT" box. • Document IM injection sites as follows: Rt: right; Lt :left; D: deltoid; VG: ventrogluteal region; VL: vastus lateralis region • Discontinued medications will be highlighted in yellow. • Document medication outcome / adverse drug reactions in the NN. • All medications prescribed for the treatment of diabetes (including insulin infusions) and glucose point of care testing will be documented on the Diabetes Medication Administration Record. • Cervical ripening agents are to be charted on the partogram. Exception: Misoprostil is charted in the Regular, PRN section due to q4h dosing. If administered by a physician where there is no order, documentation on the MAR is for communication purposes and the MAR verification process will be unaffected.
Once-Only, STAT, Pre-Op Medications	• Spaces provided for 8 medications • For each medication administered, indicate: date, time and medication name, dose, route & site; RN's initials.
Regular, PRN Medications *(scheduled and PRN meds)*	• Spaces provided for 7 medications • Circle times when medication needs to be administered over the 24-hour period as a visual cue. • For each scheduled and PRN medication, write in the space above the hours: Name, dose & route of medication, and frequency of administration • Indicate date, time, and dose (if a range) of each medication administration, and RN's initials.
Repeat Lab Tests	• Use for regularly scheduled lab tests. • Write out each lab test ordered, frequency, and circle the time they are to be drawn. • Indicate time when ordered tests are sent to the lab.
Additional investigations	• Indicate date, time and initial when additional ordered tests are sent to the lab.

LABOUR FLOWSHEET (OBS 93-C) – Cont'd

PARTOGRAM *(page 10 of 12)*

To be used after each vaginal examination, starting with admission, through latent, active and transition phases of the first stage of labour; and non-pushing phase of the second stage of labour.
Please note: Use abbreviations in legend at bottom of the page where indicated.

Time of Exam	• Indicate actual time when each vaginal exam is done.
2nd Stage Hour Indicator	• At full dilation, indicate "O" above this vaginal exam. • Continue charting second-stage vaginal exams on the partogram as long as patient is not pushing. Use the hour indicator row to keep track of number of hours in second stage before active pushing begins. At a minimum, hourly vaginal exams are performed in second stage. • Once pushing has begun, start charting on the Active Second Stage Record, p.11
Cervical Dilatation and Fetal Station	• Mark a "●" to indicate cervical dilatation (from 0 to 10). • Mark an "X" to indicate fetal station (from – 3 to + 3). *Use figure at bottom of page as reference* Please note: Use one column for each vaginal exam done during latent phase. However, once the woman reaches the active phase (3 cm dilatation), graph subsequent vaginal exam findings in the same number of columns to the right as the number of hours since the last exam (eg.The woman is found to be 3 cm at 10:00. The next vaginal exam is done at 13:00: findings will be graphed 3 columns to the right of the 10:00 exam.) Alert & Action Lines • Once the woman reaches the active phase (3 cm dilatation), draw a line diagonally up toward the right (denotes a dilation rate of 1 cm/hour): the ***Alert line***. This line represents the rate of expected/normal labour progress. • Also draw another diagonal line four boxes over to the right: the ***Action line***. It is placed 4 hours past the Alert line. If subsequent cervical dilation is touching/crossing the ***Action line,*** the Birthing Team must evaluate the woman's progress and consider interventions to augment labour.
Bishop's Score	• To be determined by physician or midwife prior to induction/cervical ripening. Record score in space provided.
Cervical Effacement Consistency, Position	• See legend at the bottom of the page.
Fetal Position	• Use proper acronym for documenting fetal position (use figure at bottom of page as reference.
Moulding / Caput	• Use "✓" if present.
Membranes Status, Amniotic Fluid, Colour and Quantity	• Document membranes status, amniotic fluid quantity & colour, using abbreviations in the legend at the bottom of the page.
Show	• Use "✓" if present.
Bleeding	• Document amount of bleeding, using abbreviations in the legend at the bottom of the page.
Pushing Status	• When woman is fully dilated, indicate whether she has the urge to push or not, and whether she is pushing or not (see legend at the bottom of the page). • At any point in labour, use this space to indicate the woman's involuntary pushing.
Cervical Ripening	• Use this section to document cervical ripening method/agent inserted by physician/midwife, using abbreviations in the legend. Also document dose. When inserted by physician, do not chart in the MAR on p. 9. • Please note: If misoprostil is used, consider documenting in MAR due to q4h administration and indicate which HCP is administering. If physician, no order is necessary and the MAR verification process will be unaffected.
Examiner's Name(s) or Initials	• Initial or name of care provider(s) performing the vaginal exam (sufficient space is provided for 2 names if there are co-examiners for teaching or verification purposes).

ACTIVE SECOND STAGE *(page 11 of 12)*

Start using once pushing has begun.

Fetal Health Surveillance (FHS)	• Indicate mode of fetal surveillance and fetal heart rate characteristics, using legend on p.12.
Contractions	• Note frequency and duration of contractions.
Pushing	• Indicate efficacy of pushing efforts, using abbreviations in the legend at the bottom of the page.
Maternal Position	• Note maternal position changes, using abbreviations in the legend on p.12.
Oxytocin (OXY)	• If applicable, indicate rate of oxytocin infusion in mU/min.
Comments	• Insert additional narrative notes here, as needed. If further documentation required, utilize NN.
Initials	• Initials of care provider making entries.
NOTIFICATION	• Indicate in this table when various health care providers have been initially called regarding impending birth, and time he/she has arrived. • If neonatal resuscitation is anticipated and a specialist or team are notified, record time called, time arrived, and indication for neonatal resuscitation.
COUNT	• Use this table to record instrument, needle and sponge counts during the birth process. • Original count is done with MD and RN. The RN initials in the upper half of the INIT column. • Any items added will be documented under "Added". • Final count is completed by the MD and RN. - RN initials in lower half of INIT column. - MD documents final count as correct or incorrect on Birth Record. • MD places sharps in sharp disposal container.

LEGEND (page 12 of 12)

LEGEND	• Use proposed abbreviations and symbols for common assessments and interventions documented in the flowsheets. • For *any* variable, use an asterisk * to indicate further notations have been documented in NN.

REGIONAL / PCA ANALGESIA RECORD (OBS 93-G)

HOW & WHEN TO USE?

One-page tool to use when woman is receiving regional or patient-controlled analgesia to document details related to these procedures, infusion management and assessments.

CONTENTS:

General information	• Indicate anaesthetist's name, and times he/she: – Is notified of epidural request – Arrives on unit – Initiates epidural • Indicate Route and Method of medication administration • If hospital policy calls for second person to verify initial pump settings, initial here
INFUSION	• In first row, indicate name and concentration of medications administered through epidural, spinal or patient-controlled analgesia.
MEDICATION Name & Concentration if TOP-UP	• Indicate name and concentration of top-up medication, if applicable.
INFUSION MANAGEMENT • Basal Continuous Infusion	• Indicate rate of basal continuous infusion (in mL/h).
• Top-ups	• Indicate top-up dose administered (in mL).
• Bolus PCA / PCEA	• Indicate dose of bolus through patient-controlled analgesia or patient-controlled epidural analgesia (in mL).
• Lock-out	• Indicate the time interval (in minutes) at which the pump will allow subsequent boluses.
• Max. hourly limit	• Indicate the total amount of medication allowed per hour (in mL) (includes boluses and basal infusion).
• Cumulative Totals: - Received - Attempts - Volume	• Indicate the amount of medication (in mL) that has been: - Received (injected) per hour (if PCA) or per half-hour (if PCEA) (in mL) - Total # of attempts requested by patient - Cumulative total of medication received (in mL)
ASSESSMENT	• Pain Scale: as per legend at bottom of the page. • Sensory Level & Motor Block: *If woman has received REGIONAL ANALGESIA* (eg. epidural), use these spaces to indicate the sensory level and motor block each time she is assessed, as per legend at bottom of the page. • Level of Sedation: *Only use if patient is on IV PCA* (patient-controlled analgesia), to indicate level of sedation as per legend at bottom of the page. • Bag / Syringe Change: Use ("✓") each time the infusion bag or syringe is changed. • Pump Rate Verified: *If woman has received REGIONAL ANALGESIA* (eg. epidural), use these spaces to indicate that the infusion pump was verified each time she is assessed (use "✓").
Initials	• Initials of primary care provider making entries in column.
LEGEND	• Legend for maternal assessment and infusion management variables • Indicate time of epidural catheter removal, and whether it is intact.
Signature section	• Two spaces for names & signatures of health care providers making entries.

BIRTH RECORD (OBS 93-D)

HOW & WHEN TO USE?

- Two-page tool to document summary of woman's history, pregnancy, labour and birth
- Most of the information on the Birth Record are variables in the BORN Information System
- One copy is kept in mother's chart, and other copy in baby's chart.

CONTENTS:

PAGE 1

General Information	• Gestation information • Name of woman's primary care provider
TRANSFER	• If woman was transferred for labour and/or birth, indicate institution of origin (hospital or birth center) or whether this was a planned home birth, and reason for transfer.
COMPLICATIONS OF PREGNANCY	• Indicate if there were any maternal or fetal complications during the pregnancy (check all that apply) and if a consultation (maternal or fetal) was done.
ANTENATAL CARE	• Indicate whether the woman received no antenatal care, was hospitalized or received antenatal home care during pregnancy. • If antenatal steroids were administered during this pregnancy (as noted on the Admission Record), indicate whether 1 or 2 doses were given and at how many hours before birth.
LAB RESULTS	• Enter results of common tests done during pregnancy, as per antenatal record.
LABOUR TYPE	• Indicate labour status at admission (no labour, spontaneous labour or induced labour). • If labour was induced, provide maternal/fetal indications for inductions (check all that apply) and primary reason for induction. • Record Bishop score (when applicable). • If labour was induced or augmented, provide details regarding methods used and total number of induction attempts.
FETAL SURVEILLANCE	• Indicate all methods of fetal surveillance used during labour and birth. Please note: If scalp pH was obtained, indicate results in the "Maternal/Fetal Assessments" section of the Labour Flowsheet.
INTRAPARTUM PAIN MANAGEMENT	• Indicate non-pharmacologic and pharmacologic methods of pain relief used through labour and birth (check all that apply).
OTHER MEDICATIONS USED DURING BIRTH	• Indicate administration of other drugs during the labour and birth process, and specify as indicated.
CHRONOLOGY	• Document date and time of key labour and birth events: Admission, onset of labour, rupture of membranes, full dilatation, onset of pushing, birth of baby & delivery of placenta.
MATERNAL OUTCOME	• Indicate maternal outcome following labour and birth (no transfer, transfer to other unit or institution, maternal death).

BIRTH RECORD (OBS 93-D) – Cont'd

PAGE 2

BIRTH DATA PRESENTATION	*TO BE COMPLETED BY PHYSICIAN OR MIDWIFE* • Indicate whether the baby's presentation was cephalic or breech, and specify position at birth.
TYPE OF BIRTH	• Indicate whether the woman had a vaginal or caesarean birth.
VAGINAL BIRTH (To be completed for women who had a vaginal birth)	• Operative birth: o Check off box if forceps and/or vacuum were used to assist birth. o Vacuum - Include details of intervention: times of vacuum application and removal, and number of uterine contractions while traction was applied. On graphic of fetal head, draw circle to indicate vacuum cup placement. o Forceps - Include details of intervention: times of forceps application and removal, whether rotation performed(specify positions), and number of uterine contractions while traction was applied • Shoulder dystocia: Indicate time when head was delivered. Indicate which manoeuvers were performed. Document additional details of maneuvers in narrative notes (NN). • Perineum: Indicate whether and episiotomy was performed (specify type); and whether there were lacerations (specify degree and area).
CESAREAN BIRTH (To be completed for women who had a caesarean birth)	• Indicate whether the caesarean birth was planned or unplanned. • Indicate fetal/maternal indication(s) for caesarean birth (check all that apply) and specify the primary indication for the caesarean birth. • Indicate the stage of labour and cervical dilatation (in cm) prior to caesarean. • Indicate anesthesia used for caesarean birth. • Indicate type of uterine incision.
CORD, PLACENTA, BLOOD LOSS	• Indicate presence of nuchal cord, # vessels • Type of placental delivery. Specify whether placenta appears normal or is sent to pathology (specify indication). Indicate if placenta requested by family. • Indicate approximate amount of blood loss at birth. • Specify drugs used to control bleeding, and whether manual exploration or other procedures were performed.
LABOUR AND BIRTHS COMPLICATIONS	• Indicate whether there were complications during the labour and birth process (check all that apply).
FINAL COUNT	• Indicate if final count (including instruments, needles and sponges) was correct or incorrect.
INFANT DATA	• Indicate baby's ID band no. and security bracelet no., sex, weight (in gms), and order in which baby was born if multiple pregnancy. • APGAR: Fill in score for each variable at 1, 5 and 10 minutes; calculate totals. • Birth Outcome: Indicate whether it was a live birth or a perinatal loss. • Newborn Resuscitation: Indicate interventions that were performed. Specify number of minutes between birth to sustained respirations. Additional details can be documented in the baby's chart. • Newborn conditions and complications: Indicate whether there were any complications at birth or immediately following birth. • Newborn congenital anomalies: Indicate whether congenital anomalies are suspected or confirmed (specify). • Cord blood gases: Indicate whether obtained, and if so, indicate results of arterial pH and Base Excess, and venous pH and Base Excess (if also obtained). • Indicate whether skin-to-skin contact with mother or partner was initiated (check all that apply). • Indicate type of feeding planned and when the first latch was attempted (check all that apply). • Specify name of Baby Care Provider. • Neonatal Transfer: Specify baby's destination: with mom, to Resuscitation Room/Nursery or to Special Care Nursery (SCN) / Neonatal Intensive Care Unit (NICU). If transferred to other hospital, specify hospital name and reason for transfer.
COMMENTS	• Narrative notes to complement other charting, as needed.
BIRTH TEAM PRESENT	• Check " ✔" for all health care providers who were present at birth. • Full name and signature is required for each health care provider.

INDUCTION REQUEST (OBS 93-F)

HOW & WHEN TO USE?

- One-page tool completed by primary care provider (physician or midwife) when a labour induction or cervical ripening procedure is planned and requested.
- Once completed, the request form is to be sent to the birth unit by fax or with the woman.
- Copy of the Induction Request form is kept in woman's chart.

CONTENTS:

General Information	• Heatlh care provider requesting the induction • Indicate requested date of induction and gestation information at the requested date of induction. • Type of induction: out-patient or in-patient
PRIORITY	• Indicate the urgency of induction, and follow directions regarding method of informing the birth unit of induction request.
INDICATIONS	• This section MUST be completed • Indicate maternal/fetal indication(s) for the induction. (check all that apply)
PLANNED METHOD	• Indicate cervical status to determine cervical readiness for induction. • Indicate planned method of induction.
COMMENTS/FOLLOW-UP	• Indicate significant findings from ultrasounds, labs, consultations or other pertinent information related to the woman's admission and care. • Responsible health care provider's name, signature and date.

For further information about the documentation tools and guidelines, please contact:

Champlain Maternal Newborn Regional Program
2305 St. Laurent Blvd.
Ottawa ON K1G 4J8
Tel: (613) 737-2660
Fax: (613) 738-3633
Email: cmnrpinfo@cmnrp.ca

To order copies of the intrapartum documentation tools, please contact: Printing Department at The Ottawa Hospital
Email: Printing@toh.on.ca