LABOUR FLOWSHEET

ADMISSION Complete **Medication Reconciliation** with Admission

Date (yyyy-mm-dd): **Time:**

ADMITTED FROM:
❑ Home ❑ Other: _____
Information (source) ❑ Patient ❑ Other: _____
Reason for admission

Languages ❑ English ❑ French ❑ Other: | Translator:

Partner/Other: Tel. no.:

Visiting restrictions: ❑ no ❑ yes
(specify):

ALLERGIES ❑ None ❑ Bracelet applied ❑ Yes (specify):

PERTINENT MEDICAL HISTORY ❑ None

WA ❑ D ❑ ND ❑ NA ❑ Other *

FALL RISK ASSESSMENT
❑ Impaired mobility
❑ Fall within last 3 months
Other: _____ Comment: _____
At risk: ❑ no ❑ yes ❑ see notes
Interventions: ❑ Universal ❑ Individualized

OAR 1 ❑ Reviewed ❑ Unavailable
OAR 2 ❑ Reviewed ❑ Unavailable

Patient history ❑ Reviewed ❑ Unavailable

STREP B

G	T	P	A	L	EDB	Gest.

Active labour onset yyyy / mm / dd Time

MEMBRANES (at admission) ❑ Intact
❑ Ruptured at: Date Time

❑ Clear ❑ Meconium
❑ Foul smell ❑ Bloody

PROBLEMS WITH THIS PREGNANCY ❑ None

STEROIDS **Date:**

PROBLEMS WITH PREVIOUS BIRTHS ❑ None

❑ Orientation to unit

❑ **Infection prevention and control precautions initiated**
Type:

Height | **Weight** Usual Current | Pre-pregnancy **BMI** (Body Mass Index)

Comments

Admitted by: Name Signature Date (yyyy-mm-dd)

ASSIGNED NURSE / MIDWIFE

Print	Signature	Init.	Date (yyyy/mm/dd) Time	NTA ✓	NTA T / R

T - Transferring nurse (Offgoing) R - Receiving nurse (Oncoming) NTA - Nursing Transfer of Accountability ✓ - Pt agrees to bedside NTA

RELIEF

Print / Signature	Init	Print / Signature	Init

Patient: Chart no.:

MATERNAL/FETAL ASSESSMENTS

	Date / Time																
FETAL ASSESSMENT	Mode																
	FHR																
	Rhythm/Variability																
	Acceleration																
	Deceleration																
	Stimulation (scalp) / pH																
	Classification (N, AT, AB)																
UTERINE ACTIVITY	Mode																
	Frequency																
	Duration																
	Intensity																
	Resting tone																
IV MED.	**Oxytocin OXY** mu/min																
MATERNAL ASSESSMENT	**Blood Pressure** 200 / 180 / Systolic ∨ / 160 / 140 / Diastolic ∧ / 120 / 100 / **Pulse** • / 80 / 60 / 40																
	Temperature																
	Respiration																
	O_2 sat.																
	Breath sounds																
	Arterial line (✓, F, Z)																
	Reflexes																
	Pain scale																
	Vaginal exam (✓)																
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	Emotional support																
	Teaching																
	Comfort measures																
	Activity/Position																
	Analgesia																
INTERVENTIONS	Position : change																
	Fluid BOLUS (mL)																
	O_2 (8-10 L/min)																
	Physician notified																
	Fall risk (✓/+)																
	Interventions (U, I)																
	Hourly rounding ✓																
	Init.																

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Patient: Chart no.:

INTAKE										OUTPUT								INIT
DATE :		Type/Amount of IV solution					B New bag			P Proteins K Ketones B Blood								
		1	2	3	4	5	6	Hourly	Cummulative									
Time	PO									Time	URINE mL	Other	Dipstick P	Dipstick K	Dipstick B	Hourly	Cummulative	

Total 24 hour INTAKE = **mL**	PREVIOUS cumulative balance ± = **mL**
Total 24 hour OUTPUT = **mL**	Cummulative balance ± = **mL**
24 hour BALANCE = **mL**	**Indwelling Catheter Insertion** # FR By Date (yyyy-mm-dd) Time

DATE	Time	Gauge	Attempt	1% buffered Lidocaine	Saline lock ✓	Sites	Main-line solution	Init.

URINE: **V** Void **C** In/Out Catheterization **F** Indwelling catheter

Patient: Chart no.:

MEDICATION ADMINISTRATION RECORD **- ONCE-ONLY / STAT / PRE-OP**

Date	Time	Medications/ IV / Blood products	Dose	Route	Site	Init.

REGULAR / PRN MEDICATION	Date			
	Init.			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24				
	Init.			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24				
	Init.			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24				
	Init.			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24				
	Init.			
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	Init.			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24				
	Init.			
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24				

REPEAT LAB TESTS	Date	Time	Init.	Date	Time	Init.
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24						

Date	Time	Additional investigations	Date	Time	Additional investigations

Pre-eclampsia Bloodwork: CBC, electrolytes, urea, creatinine, urate, AST, ALT, LDH, bilirubin, albumin, random glucose

Patient: Chart no.:

PARTOGRAM

Draw alert / action lines in active labour

DATE (yyyy/mm/dd):

Exam Time

2nd stage hour indicator **Hours**

CERVICAL DILATATION (cm)

10 9 8 7 6 5 4 3 2 1 0

STATION -3 -2 -1 0 X +1 +2 +3

Prior to induction
Bishop's Score _____

Cervix effacement (cm/%)

consistency

position

Moulding Caput

Fetal position

Membranes

Quantity of amniotic fluid

Colour

Show (✔ if present)

Bleeding

Pushing status

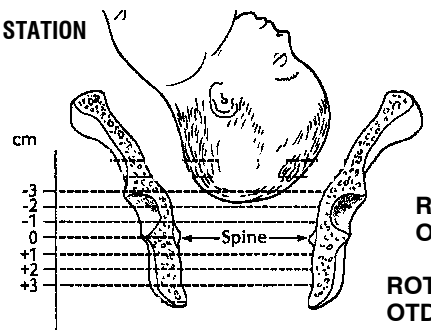
Cervical ripening/Dose

C Cervidil **M** Misoprostil **P** Prostin
F Foley **L** Laminaria

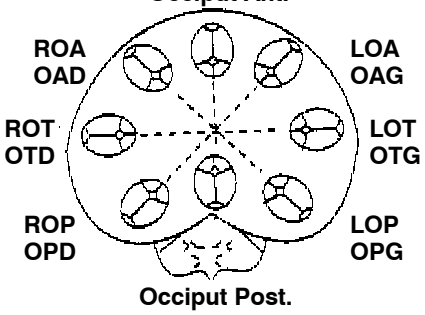
Examiner(s)

or INIT.

STATION



POSITION



MEMBRANES
- **I** Intact
- **S** Spontaneous rupture
- **A** Amniotomy

AMNIOTIC FLUID
- **Ø** None
- **M** Moderate
- **CI** Clear
- **B** Bloody
- **SC** Scant
- **L** Large
- **BT** Blood Tinged
- **M** Meconium

PUSHING STATUS
- **P** Pushing
- **NP** Not pushing
- **UP** Urge to push
- **NUP** No urge to push
- **IP** Involuntary pushing

CONSISTENCY
- **S** Soft
- **F** Firm
- **M** Medium

CERVICAL POSITION
- **A** Anterior
- **M** Mid position
- **P** Posterior

BLEEDING
- **SC** Scant
- **M** Moderate
- **L** Large

Patient: Chart no.:

ACTIVE SECOND STAGE

Time	FHS					CONT.		Pushing	Mat. Position	OXY mu/min	Comments	Init.
	Mode	FHR	Var. Rhythm	Accel.	Decel.	Freq.	Dur.					

NOTIFICATION	Time called	Time arrived
Obstetrician/GP/Midwife		
Resident		
Intern/Medical student		
Pediatrician/Neonatologist		
Neonatal resuscitation Team		

COUNT	FIRST	ADDED	FINAL	INIT.
Instruments				
Needles				
Sponges				
Other				

Indication

PUSHING EFFICACY: **E** = Effective **NE** = Non effective **NP** = Not pushing

Patient: Chart no.:

LEGEND

FETAL ASSESSMENT

Mode: **A** Auscultation **NST** Non stress test
EFM: **Ext** external **Int** Internal

Baseline FHR (AUSC/EFM): ___ bpm

Rhythm (AUSC) : **R** Regular **I** Irregular

Variability (EFM):
↓ Minimal (less than or equal to 5 bpm) + Moderate (6-25 bpm)
↑ Marked (greater than 25 bpm) **Ø** Absent

Accelerations (AUSC/EFM):
√ Present/Spontaneous **Ø** Absent/Not heard **SS** Scalp stimulation

Decelerations (AUSC/EFM):
√ Present/Heard **Ø** Absent/Not heard
E Early **L** Late *
P Prolonged *
UV Uncomplicated variables *
CV Complicated variables *
___* ↓ ___bpm x___sec/min ___

CLASSIFICATION
Auscultation : **N** Normal **AB** Abnormal

Electronic Fetal Monitoring:
N Normal **AT** Atypical **AB** Abnormal

Non Stress Test:
N Normal **AT** Atypical **AB** Abnormal

UTERINE ACTIVITY

Mode: **P** Palpation **T** Toco **I** IUPC
Intensity: **MI** Mild **MO** Moderate **ST** Strong ___ mmHg (IUPC)
Resting Tone:
SO Soft **F** Firm ___ mmHg (IUPC)

MATERNAL ASSESSMENT

Arterial line: ✓ Within normal limit
* includes site, patency, wave form, pressure bag
F Flush **Z** Zero
Breath sounds: ✓ Clear, good air entry
AB * ↓ air entry, crackles and wheezes

Reflexes: **Ø** Absent
1+ Weak **2+** Normal
3+ Increased **4+** Brisk with clonus

Pain scale:
0-10 None to excruciating

MATERNAL ASSESSMENT

Emotional Status:
C Calm **A** Anxious **P** Panicky **D** Difficulty coping
E Exhausted **S** Sleeping

Membranes : **I** Intact
SRM Spontaneous rupture of membranes
ARM Artificial rupture of membranes

Amniotic fluid: **Ø** None **SC** Scant
M Moderate **L** Large **Cl** Clear
BT Blood Tinged **B** Bloody **M** Meconium

Show/Vaginal Bleeding:
SC Scant **M** Moderate **L** Large

Woman abuse (WA)
D Disclosure **ND** Non disclosure **NA** Not able to ask

SUPPORTIVE CARE

Emotional support
A Undivided attention **F** Feedback
SP Support to partner **P** Presence: Continuous
R Reassurance/praise **D** Distraction techniques

Teaching
I/A Induction / Augmentation **CB** Cesarean Birth
LP Labour Progress **PC** Peri Care
RT Relaxation Techniques **SS** Second Stage
PR Pain Relief Options **BT** Breathing Techniques
PB Preterm Birth **H** Hypertension
GC Grief Counselling

Comfort measures
CC Cool compresses **M** Massage
WC Warm compresses **BB** Birth ball
IP Ice pack **CP** Counterpressure
F Fluids **S** Shower
PC Pericare **WP** Whirlpool
B Bath

Position/Activity:
A Ambulating **C** Chair
HK Hands & knees **KC** Knee-chest
RL Rt lateral **Li** Lithotomy
LL Lt lateral **S** Squatting
WL Wedge left **SF** Semi-Fowler's
WR Wedge right **T** Trendelenberg

FALL SAFETY

Assessment:
✓ Ambulates independently, is alert & oriented, no visual or hearing deficits or is utilizing corrective devices
+ Patient has factor(s) that may increase fall risk

Intervention (as per policies):
U Universal interventions for all patients
I Individualized interventions for patients at higher risk

Factors that may increase fall risk:

Related Diagnoses:
Cognitive impairment (eg.: delirium, street drugs, ETOH), vertigo, symptomatic hypotension
Pre-existing conditions (diabetes, arrhythmias, pre-eclampsia, seizures)
Hemorrhage

Mobility:
Requires assistance (eg.: PCEA, early PP)
Unable to ambulate or transfer

Medications:
Sedatives, opioids, antihypertensives, anti-convulsants

Use * if details noted in Integrated Progess Notes