Optimal health
for women, babies,
and families

A Companion Guide for Completion of the Nova Scotia Labour Partogram

Reproductive Care Program of Nova Scotia
RCP

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July 2010

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5991 Spring Garden Road
Suite 700
Halifax, NS B3H 1Y6
(902)470-6798

http://rcp.nshealth.ca

RCP would like to acknowledge the B.C. Perinatal Health Program for their guidance, collaboration and support in creating this Companion Guide.

Introduction

The Nova Scotia Labour Partogram (RCP 03) is a revised form developed to support perinatal care providers in the assessment and documentation of pertinent information about labour and birth in a structured, logical, and standardized manner. Its main purpose is to facilitate consistent and complete documentation, communication, and continuity of care among health care providers and provides a guide for evidence-based intrapartum care. Secondly, specific fields in the Partogram are collected as part of the Nova Scotia Atlee Perinatal Database (NSAPD), which includes data collection from all Provincial Perinatal Forms. These data are collected, analyzed, and disseminated to Nova Scotia DHAs/IWK to inform the monitoring of provincial perinatal outcomes and to improve health care planning and provision.

Guiding Principles

The NS Labour Partogram is designed for use in conjunction with the NS Prenatal Record, the NS Maternal Assessment form (RCP 02), the Birth Record (RCP 04), and the Mother-Baby Flowsheet (RCP 05).

Several key principles guided the design and development:

- Be applicable for all maternity sites offering different levels of perinatal care
- Be usable from labour admission through birth to beginning of 4th stage
- Incorporate relevant intrapartum assessment and interventions
- Be adaptable to charting by exception or variance charting
- Minimize double charting or need for narrative notes on several forms
- Utilize standard terminology and abbreviations
- Focus on support for normal labour and birth process
- Facilitate early recognition, timely communication and intervention for changes in labour progress and/or maternal and/or fetal conditions
- Support multidisciplinary use
- Facilitate data collection for NSAPD
- Enable electronic archiving or formatting

General Guidelines

- The NS Maternal Assessment form provides the admission history and complements documentation on the Labour Partogram
- Initiate Labour Partogram when woman is admitted:
    - In active labour: active (first stage) of labour is defined as 'regular, frequent uterine contractions accompanied by cervical changes (dilatation and effacement) from 3-4 cm to full dilatation and effacement of the cervix'. In the NSAPD, the proxy for the onset of active labour is when the cervix is 4 cm dilated.
    - For induction of labour. **A separate documentation form or progress notes are used for cervical ripening.**
- Assess relevant history and pregnancy information by:
    - Interviewing the woman
    - Reviewing:
        - The Nova Scotia Prenatal Record (RCP 101) parts 1, 2, and 3
        - Other relevant medical documentation (e.g. ultrasound reports)
- Perform a maternal physical and psychosocial assessment
- **For Variance(s) – use an asterisk (*) in any space when further details about assessment, interventions or communication have been documented in the Progress Notes**
- For any identified variances:
    - Document on the Progress Notes
    - Communicate with the primary care provider (PCP) or designate and document:
        - Exact time of notification
        - Nature of communication
        - Responses of PCP
        - Plan of action
        - Response or evaluation of outcomes
- A blank space indicates that the action or assessment was not performed
- When more than one Labour Partogram is required, the time will be continuous
- **You may find it helpful to detach the first page (along the perforated edge) from the remainder of the Labour Partogram.** This may be placed separately in the woman's health record, or turned over so the reference Key for documentation may be more readily visualized. Cervical assessment typically occurs much less frequently than other assessments in labour so you may find it unnecessary to have the labour curve present and available at all times.

The following sections provide descriptive information on the items on the Labour Partogram

- Under the 'item' column, data fields collected in the NSAPD are identified with an asterisk (*)
- The term 'document' instructs the recorder to write out the requested information in the space provided, using the appropriate abbreviations when applicable
- The term 'indicate' instructs the recorder to check (✓) the box provided

Page 1: Key Background Information

- Brief summary of key information regarding the woman's admission history, labour, and birth plan
- Complements information found on the Nova Scotia Prenatal Record and the Maternal Assessment

Item	Description
Addressograph/Label area	Demographic information includes: woman's surname, given name, address, phone number, Nova Scotia Health Card number, hospital unit number, date of birth, PCP name, date of admission
Gravida*	Document the total number of prior and present pregnancies for this mother. Twins or multiples are counted as one pregnancy, as are blighted ova and hydatidiform moles.
Para*	Document the total number of pregnancies that have resulted in a living child or children or in stillbirths which are greater than or equal to 500 g or 20 weeks gestation. For twins, there is one pregnancy, therefore gravida is 1 and para is 1 (G_1P_1).
Gest: _____ wks	Gestational age is determined by number of weeks from LMP when the woman is certain of her dates, and her periods are regular with a normal cycle length. The EDD can be reliably determined by an ultrasound at 10-13 weeks. The date may be established on the basis of a 20 week ultrasound if that date differs from the LMP date by 10 or more days.
Allergies	Document if the woman has any allergies; specify and document adverse reactions.
Blood group/Rh	Document the woman's ABO and Rh blood typing.
Antibodies*	Document any known antibodies, particularly those associated with Haemolytic Disease of the Newborn.
Date/time active labour established	Determined by full effacement or cervix 3-4 cm dilated, in the presence of regular painful uterine contractions.
SRM (spontaneous rupture of membranes)* ARM (artificial rupture of membranes)*	Indicate either SRM or ARM, noting the date and time and a description of the amniotic fluid (e.g. colour, odour, amount).

Page 1: Key Background Information (cont'd)

Item	Description
GBS (Group β streptococcus) status*	Indicate whether results are positive, negative, or unknown.
Birth Plan	Review and document the woman's plan for her birth (whether formally written or expressed verbally). Topic examples include role of support person(s); choice of comfort and pain relief methods; goals, plans, expectations, concerns, questions, and fears.
Support person(s)	Document name(s) of support person(s).
Risk factors/concerns	Document any risk factors or concerns the woman may have. Make particular note of any risk factors that may influence the management or outcome of her labour and/or birth.

Page 1: Vaginal Exam

- The Labour Partogram is a visual aid to indicate and assess progress in labour.

Item	Description
Date and time*	Record date and time. Begins at the hour during which the woman is admitted in labour or for induction (e.g. the woman is admitted at 0820h – the first time column should read 0800h). The line on the left of each column denotes the full hour i.e. 0800h, 0900h, etc.
Hours	Time columns are divided into hourly intervals.
Cervical dilatation*	Determine the dilatation of the cervix (0 – 10 cm) with vaginal examination and indicate using '•' on graph in accordance with the appropriate time, relative to the hourly marks. For example, if a woman is examined at 0830h and her cervix is 3 cm dilated, place '•' in the middle (to denote the half hour mark) of the horizontal line indicating 3 cm.

Page 1: Vaginal Exam (cont'd)

Item	Description
Station	Using 'X', document the descent of the presenting part (from -3 to +3) on the graph in the same column as the cervical dilatation.
Effacement	Document findings in % relative to complete effacement (100%)
Cx position/consistency	Document the position of the cervix: A = anterior M = mid P = posterior Document the consistency of the cervix: S = soft M = medium F = firm
Presenting part position	Document the position of the presenting part: L = left R = right A = anterior O = occiput P = posterior Oth = other* (describe in progress notes)
Moulding/caput	Document whether moulding or caput are present. If marked, describe in progress notes M = moulding C = caput
Amniotic fluid	Document whether amniotic fluid is present per vagina, and note appearance. If assessment findings are atypical, describe in progress notes: Ø = absent Sc = scant Mod = moderate L = large Cl = clear Bl = bloody Mec = meconium
Blood/show	Document whether blood or show is present per vagina, and note appearance. If assessment findings are atypical, describe in progress notes: Sc = scant Mod = moderate L = large

Page 1: Vaginal Exam (cont'd)

Item	Description
Examiner	Name or initials of examiner are recorded here. If initials are used, identify these with the printed name and status of the examiner in the appropriate spaces on page 4 of the Labour Partogram.

Page 1: Medications

- If using a separate Medication Administration Record to document medications, indicate using '✓'.
- If recording medications on the Labour Partogram, include time, medication name, dose, route (e.g. insulin, antibiotics or narcotics). Sign or initial.

Page 1: Patient and Family Teaching

- Suggestions for teaching points to include during labour and birth; initial if discussed with woman or her partner or family. It is clear that more than one care provider may provide teaching on any particular topic, and so space is provided for more than one set of initials.

Topic	Description
Labour Progress	• Describe how labour starts; moving from early to active labour, transition and second stage • Review 'progress' – i.e. the cervix thins, moves to anterior position, and dilates and the baby descends to station '0' to +1 to + 3 to birth; the baby's head flexes, rotates and extends during the birth process. • Explain the importance that labour once started continues, with contractions that generally become more regular, more frequent and last longer. • Describe how progress is determined – by assessment of contractions, other physical signs of progress such as blood show, feelings of pressure and change in sensations, and by vaginal examination. Encourage her to let you know if she experiences new sensations. • Suggest how progress may be promoted through walking, an upright position, comfort and relaxation techniques, or by having membranes ruptured.
Breathing/Relaxation Techniques	• Review the benefits of slow breathing and not breath-holding – e.g. more oxygen for the baby, avoidance of tightening and discomfort of all muscles, promoting progress. • Demonstrate to support person how to provide lower back counter- pressure, massage, use ice or hot packs; remind them that not all things 'work' at all times throughout labour.

Page 1: Patient and Family Teaching (cont'd)

Topic	Description
Positioning for Labour and Birth	• Suggest frequent position changes and give rationale that includes prevention of muscle strain, skin irritation, and benefits with respect to labour progress • Promote more upright and/or mobile positions as appropriate • Suggest and demonstrate positions as appropriate e.g. hands and knees, side lying with pillow supports, leaning over birthing ball, sitting backwards in a chair, walking, swaying, etc. • Describe more upright positions and frequent position changes if the woman chooses epidural analgesia
Grief Counseling	• This will be very individualized and dependent on situation and establishing a relationship; generally refers to ongoing support.
Induction/Augmentation	• Discuss the indication for induction • Review the chosen method of induction, what it involves and the expected response • Describe the nurse's role in safely administering oxytocin infusion (if indicated) e.g. how the infusion is titrated and the assessments that are required. • Explain fetal surveillance that is recommended including rationale • Explain the rationale for augmentation in terms of labour progress
Birth Plan	• Encourage her to talk about her expectations for labour and birth to clarify misconceptions and to negotiate how you will support her • Help her identify what things are most important to her (Additional documentation may be indicated)
Pain Relief Options	• Find out about what she expects with respect to pain and pain relief during labour • Review non-pharmacologic pain relief measures such as massage, deep breathing, shower/bath, or use of hot or cold. • Reassure her of nurses' support during labour • Review three options for pharmacologic measures for pain relief (e.g. nitrous oxide, narcotics, and epidural) respecting her birth plan. Discuss her preferences. For example, if she says she does not want to have an epidural, focus on other medications available. Include discussion of risks of medication including a possible effect on early breastfeeding.
Breastfeeding	• Review the benefits of early and regular skin-to-skin (for all babies). • Describe baby-led latch, frequency of feeding, positions • Review the possible effects of narcotics on early breastfeeding
Second Stage of Labour	• Discuss common sensations as second stage approaches and progresses; encourage her to respond to her body's urge to push • Review positions of most comfort during 2nd stage (e.g. more upright position)

Page 1: Patient and Family Teaching (cont'd)

Topic	Description
Cesarean Birth	• Prepare her about what to expect in the Operating Room and recovery area
Preterm Birth	• Inform the parents about additional team members who will be providing care for their baby
Other	• Describe topic and teaching points in Progress Notes

Page 2/3:

- #____ of ____: if more than one Partogram is used during the woman's labour, record the respective sequential number of each Partogram (first blank) in a total of (second blank) forms. E.g. if 3 Partograms have been used during a woman's labour, record '#1 of 3' on the initial form, '#2 of 3' on the next form, and '#3 of 3' on the final form.

Page 2/3: Fetal Health Surveillance

- Definitions are in accordance with the SOGC 2007 Fetal Health Surveillance: Antepartum and Intrapartum Consensus Guideline
- For quick reference, abbreviations are listed in the reference Key on Page 6 of the Labour Partogram.
- Recommended frequency of auscultation:
    - Immediately following a contraction for a full minute
    - First stage: latent phase – approximately q1h if more than 4 contractions/hour, otherwise as clinically indicated (ideally the woman is at home). Assess for signs of active labour.
    - First stage: active phase – q15 to q30 minutes.
- EFM (electronic fetal monitoring) tracing characteristics should be recorded using the key q15 to 30 minutes
- Check the time on the electronic fetal monitor and synchronize this time with the clock in the room and/or your watch to be sure all times are the same. If this is not possible, note a difference in the times and use the monitor time as your source.
- Check and know the paper speed of the monitor. In Nova Scotia, all facilities are currently using a paper speed of 3 cm/minute.

Page 2/3: Fetal Health Surveillance (cont'd)

Item	Description
Date and time	Record date and time of assessment.
Rate	Record mean FHR as a single number. The normal fetal heart rate (FHR) is 110 – 160 bpm. Assess by listening for 60 seconds following a contraction, if feasible, and assess regularly to ensure it is within the same range after the contraction as it was in the previous assessments. If not, assess possible causes for the change and record in Progress Notes.
Mode*	Document fetal surveillance method used. Intermittent auscultation (IA) is recommended for healthy women without risk factors for adverse perinatal outcomes. IA = intermittent auscultation E = external Electronic Fetal Monitoring (EFM) S = spiral/internal EFM
Accelerations	If using IA, document: ✓ = heard Ø = not heard If using EFM, document: ✓ = present Ø = absent* (describe in Progress Notes)
Decelerations	If using IA, document: ✓ = heard* (describe in Progress Notes) Ø = not heard If using EFM, document: Ø = absent E = early* V = variable* L = late* P = prolonged* *documentation includes ↓_____ bpm x _____ seconds or minutes, and management (e.g. nursing interventions and response to interventions)
Rhythm (IA)	Document the rhythm of the FHR with IA: R = regular I = irregular

Page 2/3: Fetal Health Surveillance (cont'd)

Item	Description
Variability (EFM)	Document the variability of the FHR when using EFM: Ø = absent* (undetectable) ↓ = minimal (≤ 5 bpm) + = moderate (6 – 25 bpm) ↑ = marked (> 25 bpm)
Classification	Classify the EFM FHR tracing as: N = normal Atyp = atypical Abn = abnormal **Describe specific interventions for atypical or abnormal findings and response to the interventions in the Progress Notes. Also document notification of the physician, midwife, and/or other members of the team**.

Page 2/3: Contractions

Item	Description
Frequency	Frequency is determined by measuring the time interval from the beginning of one contraction to the beginning of the next, by palpation or EFM. Document the frequency observed in the preceding 15-30 minute interval, depending on the woman's clinical situation (e.g. q 2 ½ - 4 minutes)
Duration	Document the length of time in seconds the contraction lasts, from beginning to end (i.e. 45 – 60 sec).
Intensity	Document the strength of contractions determined by palpation: M = mild Mod = moderate S = strong If using an Intrauterine Pressure Catheter (IUPC), document the value recorded ____ mmHg
Resting Tone	Document the resting tone of the uterus between contractions: S = soft F = firm If using an Intrauterine Pressure Catheter (IUPC), document the value recorded ____ mmHg

Page 2/3: Oxytocin Rate*

- Document the infusion rate in mU per minute.
- Indicate with '✓' if oxytocin is being used to:
  - Augment labour (to improve contractions after labour has started spontaneously) OR
  - Induce labour (to initiate labour prior to its spontaneous onset)
- Document the time and rate (mU/min) in the appropriate columns.

Page 2/3: Maternal Assessment

Item	Description
Blood pressure	Document systolic and diastolic blood pressure and time in the appropriate columns. If findings are atypical, indicate with * and describe further assessment and interventions (if applicable) in Progress Notes. The SOGC (2008) guideline on the *Diagnosis, Evaluation, and Management of the Hypertensive Disorders of Pregnancy* recommends the following approach to blood pressure monitoring: "1. BP should be measured with the woman in the sitting position with the arm at the level of the heart. 2. An appropriately sized cuff (i.e., length of 1.5 times the circumference of the arm) should be used. 3. Korotkoff phase V should be used to designate diastolic BP. 4. If BP is consistently higher in one arm, the arm with the higher values should be used for all BP measurements. 5. BP can be measured using a mercury sphygmomanometer, calibrated aneroid device, or an automated BP device that has been validated for use in preeclampsia. 6. Automated BP machines may underestimate BP in women with preeclampsia, and comparison of readings using mercury sphygmomanometry or an aneroid device is recommended."
TPR*	Document the maternal temperature, pulse and respiratory rate (e.g. 37^{3} – 88 – 22) in the appropriate time columns. If findings are atypical, indicate with * and describe further assessment, interventions, and response (if applicable) in Progress Notes.
O_2 Saturation	Document oxygen saturation as measured by the O_2 saturation monitor, at least every 15 minutes when indicated (e.g. following administration of Fentanyl). If findings are atypical, indicate with * and describe further assessment and interventions (if applicable) in Progress Notes.

Page 2/3: Maternal Assessment (cont'd)

Item	Description
Emotional Status	If appropriate (e.g. if she is awake), ask the woman how she is feeling/coping and document: Ax = anxious Cl = calm CW = coping well D = difficulty managing Ex = exhausted P = panicky S = sleeping If none are applicable, indicate with * and describe further assessment in Progress Notes. Describe interventions under 'Supportive Care' and ongoing effectiveness evaluated here or in Progress Notes.
Activity	Document the activity or position of the labouring woman using free text OR the following suggestions: Amb = ambulating BB = birthing ball C = chair RL = right lateral LL = left lateral Su = supine Li = lithotomy Tr = Trendelenberg HK = hands and knees KC = knee-chest SF = semi-Fowler's Sq = squatting WL = wedge under left WR = wedge under right
Supportive Care measures	Document non-pharmacologic measures used to support the labouring woman, using free text OR the following suggestions: At = aromatherapy CC = cool compresses CP = counterpressure Fl = fluids IP = ice pack M = massage Mu = music Rf = reflexology Sh = shower T = tub/whirlpool TE = TENS Pc = pericare WC = warm compresses Oth = other

Page 2/3: Regional Analgesia

<table>
<tr><th>Item</th><th>Description</th></tr>
<tr><td>Epidural, Spinal, Combined, PCEA*</td><td>Indicate the type of regional analgesic used:
Epidural
Spinal
Combined
PCEA (Patient controlled epidural analgesia)</td></tr>
<tr><td>Bolus at _____ h.</td><td>Document the time the regional analgesic initial bolus was administered.</td></tr>
<tr><td>Continuous infusion at _____ h.</td><td>Document the time the continuous infusion of regional analgesic was commenced.</td></tr>
<tr><td>Dr.</td><td>Document the name of the anaesthetist who initiated the regional analgesia and/or who is providing ongoing care.</td></tr>
<tr><td>Bolus/Rate</td><td>Document when a bolus of regional analgesic has been administered, or the rate of continuous infusion.</td></tr>
<tr><td>R/L Sensory</td><td>Document the right and left sensory levels, testing with ice for numbness and indicate where the ice does not feel cold as:
<table><tr><th>Dermatome Level</th><th>Anatomical Landmark</th></tr><tr><td>T4</td><td>Nipple level</td></tr><tr><td>T6</td><td>Xiphisternum</td></tr><tr><td>T8</td><td>Subcostal margin</td></tr><tr><td>T10</td><td>Umbilicus</td></tr><tr><td>T12</td><td>Suprapubic level</td></tr><tr><td>L2</td><td>Anterior thigh</td></tr></table></td></tr>
<tr><td>R/L Motor</td><td>Document the right and left motor block levels as:
0 = none – No motor block; full flexion of feet/knees
1 = partial – Just able to move feet and knees, unable to raise extended legs (acceptable)
2 = almost complete – Able to move feet only; unable to bend knees
3 = complete – Unable to move feet, knees, or hips

If motor block has been assessed at level 2 or 3, the care provider may consider notifying the anaesthetist in accordance with institutional practice and/or policies.</td></tr>
</table>

Page 2/3: Regional Analgesia (cont'd)

Item	Description
Effect/Sedation	Document the effectiveness of the regional analgesia: E = effective P = partially effective I = ineffective Assess and document sedation using the following scale: 0 = alert 1 = sometimes drowsy/easily aroused 2 = often drowsy/easily aroused 3 = often drowsy/difficult to arouse **If sedation level has been assessed at level 3, the care provider may consider notifying the anaesthetist in accordance with institutional practice and/or policies.**
Pt. Position	Document the position of the woman using free text OR the suggestions listed above under 'Activity' in the section title 'Maternal Assessment'.
Initials	Provide legible initials of the care provider completing the assessment. Initials should be paired with the printed name, signature and status of the recorder on page 4 of the Labour Partogram.

Page 4: Progress Notes

- Document in chronological order any pertinent information, variances, nursing actions, responses, or evaluation obtained during the maternal or fetal assessment.

Page 5: Second Stage of Labour

Item	Description
Full dilatation at:*	Document the date and time the woman became fully dilated.
Active pushing started:	Document the date and time the woman commenced active pushing.
If applicable: Foley removed	Indicate if applicable and document the time when the Foley catheter was removed.
MD/RM notified at _____ h. Arrived at _____ h.	Document the time the MD or RM (physician or midwife) was notified and the time of their arrival.
FHR mode*	Document fetal surveillance method used. Intermittent auscultation (IA) is recommended for healthy women without risk factors for adverse perinatal outcomes. IA = intermittent auscultation Ext. EFM = external electronic fetal monitoring Int. EFM (spiral) = internal electronic fetal monitoring.
Time/FHR/Notes	Document the exact time and FHR: • Immediately after a contraction for a full minute • Passive second stage – q 15 minutes before the onset of pushing • Active second stage – q 5 minutes (after a contraction) once the woman has begun pushing For more information on fetal health surveillance interpretation and documentation standards, please see pages 9-11. Document narrative notes during second stage, and any pertinent information as required.

Page 5: Vaginal Birth

- Document key birth events relevant to the immediate third and fourth stages of labour.

Item	Description
Mother's position for delivery*	Indicate the woman's position at the time of baby's birth: Semi-sitting Side-lying Squatting Supine Other (use free text to describe)
Delivery of male/female at _____ h by SVD, Vacuum*, or Forceps*	Document the gender of the baby and time of birth, and indicate whether the birth was spontaneous or assisted. For assisted vaginal birth additional documentation is recommended: For vacuum, document: Type of vacuum Time of application Time of removal Number of pop-offs (recommended maximum ≤ 3) If vacuum delivery was unsuccessful For forceps, document: Type of forceps Time forceps applied Time forceps removed If forceps delivery was unsuccessful For BOTH forceps and vacuum, document: Name of care provider performing the assisted vaginal birth Name of person assisting, if applicable Pertinent comments pertaining to the assisted vaginal birth
Oxytocin: _____ units given	Document the number of units given and indicate route (IM or IV) and the time of administration: Anterior shoulder Before placenta After placenta delivered Not given (document reason not given)
Attending staff NRP trained	Indicate whether care providers attending the baby at birth have current training in the Neonatal Resuscitation Program
Resus Team/MD/RT called for delivery:	Indicate additional team members required to support infant resuscitation and document reason called.

Page 5: Initial Mother-Baby Contact

Item	Description
Skin-to-skin contact*	Indicate whether skin-to-skin contact was initiated and document the time and duration. Skin-to-skin is recommended for all stable babies, regardless of feeding method.
Baby latched to breast*	Indicate whether baby latched on the breast; provide relevant details in the description.
None of above: Reason	Indicate if neither skin-to-skin contact nor breast latch occurred, and document reason.

Page 6: Fourth Stage: Postpartum Assessments

- Maternal postpartum assessments should be completed every 15 – 20 minutes for at least the first hour in accordance with standards set by your institution, and more frequently if indicated by atypical findings.

Item	Description
Time	Document the time of the assessment and findings within the appropriate time column.
B/P, pulse	Document assessment findings.
Temperature	Assess within first hour following birth and document findings.
Lochia	Assess and document character and amount of vaginal blood loss Scant: <2.5 cm on menstrual pad/1 hour Light: <10 cm on menstrual pad/1 hour Moderate: <15 cm on menstrual pad/1 hour Heavy: saturated pad in 1 hour Excessive: saturated pad in 15 minutes
Perineum	Examine and document status of perineum (e.g. intact, degree of laceration, sutures in place, swelling, bruising, ice pack applied)

Page 6: Fourth Stage: Postpartum Assessments (cont'd)

Item	Description
Fundus	Assess contractility (e.g. firm, firm with massage, boggy) and location of uterine fundus in relation to umbilicus (e.g. midline, left of midline). Note cm below or above umbilicus.
Voiding	Document time and amount of urine output (mL), and whether the woman voided without assistance or required catheterization.
Initials	Provide legible initials of the care provider completing the assessment. Initials should be paired with the printed name, signature and status of the recorder on page 4 of the Labour Partogram.
Epidural Catheter removed intact by _____	Indicate whether epidural catheter was removed intact and by whom; document date and time
Tub/shower, Bed bath	Indicate whether the woman was up to the tub or shower post-delivery, or whether she was assisted with personal hygiene at the bedside.
Mother/Infant to Room #_____	Document the room number to which the mother and her infant were transferred, including the date and time. Indicate whether they were transferred via wheelchair or stretcher.
Infant transferred to nursery	Indicate whether the infant was transferred to a nursery separate from the mother, and document the reason.

Note: In cases of third and/or fourth stage complications such as postpartum hemorrhage or retained placenta, please provide detailed documentation, including medications given, in the Progress Notes and/or on the Medication Administration Record (MAR).

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Partogram Practice Scenario – Ashley and Chris

At 0830h Ashley arrives in your Labour and Birth Unit, accompanied by her partner Chris. She tells you she had a 'gush' of clear fluid at 0730h this morning, and has been having contractions throughout the night but they've been regular since 0500h.

Ashley's contractions are every 3 to 5 minutes, last approximately 45 seconds and are mild to palpation with the uterus relaxing between. Her pad reveals a moderate amount of clear fluid tinged with scant pink show. The fluid is positive for ferning. She is able to talk through her contractions and although she says the contractions are painful, she finds she is much more comfortable when she is up walking. She says she's 'feeling nervous' about labour but feels reassured since coming to hospital.

Ashley hands you her prenatal record. This is her second pregnancy; she and Chris experienced a spontaneous loss two years ago. Her LMP was 28 April. The 2nd trimester u/s and dates confirmed her EDD to be 02 February, making her 40+3/7 today.

She is A positive with a negative antibody screen, and she tested positive for GBS 4 weeks ago. She has no allergies and is otherwise healthy. Ashley doesn't have a written Birth Plan but says she just wants to have a healthy baby.

Ashley tells you the baby has been active through the night, and you examine her using Leopold's Maneuvers. She has a single fetus with a cephalic presentation in LOA position, and the head is well descended into the pelvis. The FHR is 136 using IA and an acceleration was audible during a contraction.

Vital signs assessment: 116/84, T366, P84, R18

You reassure them that both Ashley and their baby are well and that she appears to be in early labour, and discuss how labour progresses. You recommend they walk around and allow the contractions to become more regular and stronger before you examine her cervix. You review some basic comfort measures and encourage them to come to you with any questions or concerns. Chris offers Ashley a popsicle and they go down the hall for a walk. It is now 0900h. You contact her Family Doctor to give report and start using the Partogram.

At 0910h you insert an 18g IV catheter into the left cephalic vein, flush it with 3 cc NaCl, then administer Penicillin G 5 million units IV. You flush the catheter with 3 cc NaCl and cap it with a saline lock.

At 0945h, Chris returns and says "Ashley needs you". Ashley is now breathing with contractions and looks a little stressed but focused and says she's still okay. Chris has been massaging her lower back. You reassess her and the baby: 122/84, P88, R22; FHR 128 (IA) with acceleration heard. You examine her cervix and determine she is 6 cm dilated, 100% effaced, Station 0.

Ashley decides she would like to try labouring in the shower. You move a birthing ball into the shower so she can sit if she likes, and, using IA every 15 minutes, assess the FHR to be 136, 140, 132, 128, 132, 132, 142, 128 bpm with regular rhythm, accelerations heard and no decelerations. You classify the FHR.

At 1200h Ashley is in tears, wants to lie in her bed, and requests 'something for the pain'. She has much more red show PV now and is having difficulty focusing on breathing during contractions. Her FD arrives at 1210h and examines her cervix which is now 9 cm dilated, Stn +1and the baby's position remains LOA. You discuss options for pain relief and she decides to try Entonox.

By 1220h Ashley tells you the Entonox is helpful but the contractions are still 'really sharp'. You help to coach her with her breathing during contractions, assist her into a squatting position and reassure her

that this stage of labour, while intense, is usually brief. Ashley asks “What happens with the pushing?” You discuss with her and Chris what they can expect, and demonstrate different pushing positions.

At 1245h Ashley is pushing involuntarily during contractions. You examine her cervix and find it to be completely dilated, with the baby’s head at Stn +2 to +3 in OA position. You inform her FD and encourage her to begin actively pushing when she feels the urge. You listen to the FHR after every contraction and record 136, 128, 124, 124, 124, 132, 128, 124.

At 1310h Ashley’s next dose of Penicillin G is due. You check patency of the saline lock with 2 mL NaCl, administer 2.5 million units of Penicillin G, then follow with a flush of 3 mL NaCl.

Ashley’s legs are tiring, so you suggest she try pushing while lying on her right side with Chris supporting her leg. She is pushing more effectively in this position and the baby descends quickly. The FHR at 1321h is 90 bpm following a contraction and does not return to baseline. You assist Ashley to move to left lateral position and encourage her to continue pushing with the next contraction. The FHR remains at 90 bpm and the baby’s head remains on the perineum after the contraction at 1323h. Her FD suggests a vacuum extraction and Ashley agrees.

At 1325h the FD uses a straight catheter to empty Ashley’s bladder of 100mL of urine. She then applies the vacuum with Ashley breathing Entonox, and after one pull with no pop-offs, a baby girl is born at 1327h and cries immediately. She is immediately placed skin-to-skin. You administer 5 units Oxytocin in the saline lock following the delivery of the anterior shoulder.

You assist Ashley to latch the baby when she begins to root, and she latches eagerly at 1340h. The perineum has a small first degree tear which is not repaired.

The postpartum checks are unremarkable, and you accompany Ashley and the baby to their room while Chris steers the wheelchair.

Please refer to the Labour Partogram on the next pages to see an example of how it might be completed using the above Practice Scenario.

Labour Partogram

Ashley Jennings (Label)

G: 2 P: 0 Gest: 40 3/7 wks Allergies: nil
Blood group/Rh: A pos Antibodies: neg
Date/time active labour established: 05 Feb/10 @ 0500h
☑ SRM ☐ ARM Date, time, describe fluid: 05 Feb/10 @ 0730h clear
GBS: ☑ positive ☐ negative ☐ unknown

Birth Plan: "healthy baby" Support person(s): Chris
Risk factors/concerns: 0 nil 0

Date: 05 Feb 2010 Time: 0800 0900 1000 1100 1200 1300 1400 1500 1600 1700 1800 1900

Hours	0	1	2	3	4	5	6	7	8	9	10	11	12
Cervical Dilatation (•) Station (X) 9						1245h (KM)							
-3	8					1210h •							
-2	7												
-1	6		•										
0	5		X										
1	4					X							
2	3												
3	2					X							
	1												
	0												
Effacement			100%			100%							
Cx position/consistency			A/S			A/S							
Presenting part position		LOA	LOA			LOA/OA							
Moulding/caput			nil			M							
Amniotic fluid		Cl	Cl			Cl							
Blood/show		Sc	Sc			Mod							
Examiner		KM	KM			DR. OWEN							

Vaginal Examination:
Effacement = in %
Cx Position:
A = anterior
M = mid
P = posterior
Consistency:
S = soft
M = medium
F = firm
Presenting Part Position:
L - left
R = right
A = anterior
O = occiput
P = posterior
Oth = other*
Moulding/Caput:
M = moulding
C = caput
Amniotic Fluid:
Ø = absent
Sc = scant
Mod = moderate
L = large
Cl = clear
Bl = bloody
Mec = meconium
Blood/Show:
Sc = scant
Mod = moderate
L = large

Medications (☐ See separate Medication Administration Record)

Include time, medication name, dose, route, and initials (e.g. antibiotics, narcotics)				
	0910h Penicillin G 5 million units IV TKM	1215h Entonox by mask prn TKM		

Patient and Family Teaching

TOPIC	INITIALS	TOPIC	INITIALS	TOPIC	INITIALS
Labour Progress	KM	Induction/Augmentation		Second Stage of Labour	KM
Breathing/Relaxation Techniques	KM	Birth Plan	KM	Cesarean Birth	
Positioning for Labour and Birth	KM	Pain Relief Options	KM	Preterm Birth	
Grief Counseling		Breastfeeding		Other (describe)	

Partogram #1 of 1

Maternal & Fetal Assessments

Date: 05 Feb 2010 / Time	0800			0830	0845	0900		0945	1000	1015	1030	1045	1100	1115	1130	1145	1200	1215	1230	1245	1300	1315	1330	1345
Fetal Health Surveillance																								
Rate				136				128	136	140	132	128	132	132	142	128	132	136	128	138				
Mode				IA				IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA				
Accelerations				✓				✓	✓	∅	✓	✓	✓	∅	∅	✓	✓	✓	∅	∅				
Decelerations				∅				∅	∅	∅	∅	∅	∅	∅	∅	∅	∅	∅	∅	∅				
Rhythm (IA)				R				R	R	R	R	R	R	R	R	R	R	R	R	R				
Variability (EFM)																								
Classification				N				N	N	N	N	N	N	N	N	N	N	N	N	N				
Contractions																								
Frequency			q3"-5"		-		q2"-4"		q2"-4"		q2"-3"		q2-3"		q2"		q2"		q1½-2"					
Duration			45 sec				45-60 sec		45-60 sec		60 sec		60 sec		60-70 sec		60 sec		60 sec					
Intensity			M				mod-S		mod-S		mod		mod-S		S		S		S					
Resting tone			So				So		So		So		So		So		So		So					
Oxytocin rate (mU/minute) ☐ Augmentation ☐ Induction started at ______ h.																								
Maternal Assessment																								
Blood pressure				116/84				122/84		120/80		124/76		118/84		126/84			128/80					
TPR			36.6-84-18				88-22				92-20				92-22		37.2-88-20							
O_2 Saturation																								
Emotional Status			CW				CW		CW		CW		CW		CW		D		D					
Activity			Amb				Amb		BB		BB		BB		standing		LL		Sq					
Supportive Care			Fl				M		Sh/oth		Sh		Sh		Sh		M/CP		CP/M					

Regional Analgesia

☐ Epidural ☐ Spinal ☐ Combined ☐ PCEA Bolus at ______ h. Continuous infusion at ______ h.

Dr.												
Bolus/Rate												
R/L Sensory												
R/L Motor												
Effect/ Sedation												
Pt. Position												

Initials				KM				KM	KM	KM	KM	KM	KM	KM	KM	KM	KM	KM	KM	KM				

Partogram #__ of __

Time	Date		
		Rate	Fetal Health Surveillance
		Mode	
		Accelerations	
		Decelerations	
		Rhythm (IA)	
		Variability (EFM)	
		Classification	
		Frequency	Contractions
		Duration	
		Intensity	
		Resting tone	
		Oxytocin rate (mU/minute) ☐ Augmentation ☐ Induction started at _____ h.	
		Blood pressure	Maternal Assessment
		TPR	
		O_2 Saturation	
		Emotional Status	
		Activity	
		Supportive Care	
		Dr.	Regional Analgesia
		Bolus/Rate	
		R/L Sensory	
		R/L Motor	
		Effect/ Sedation	
		Pt. Position	
		Initials	

RCP 03 Revised July 2010

Printed name	Signature/Status	Initials
Kelly McNeil	K McNeil RN	KM

Date & Time	Progress Notes
05 Feb 10 @ 0900h	Dr. Owen notified via telephone of pt's status.
	Admitted in labour; ambulating accompanied by partner
	K McNeil RN
05 Feb 2010 @ 1210h	Dr. Owen in to see. Pt requesting "something for the
	pain". VE by Dr Owen - Cx 9cm 10A. Pain relief
	options discussed; pt will try Entonox. K McNeil RN
1220h	Entonox used x 2 contractions; pt states it is
	helpful but contractions remain "sharp". Will
	continue to use Entonox for now — K McNeil RN
1245h	Pushing involuntarily with contractions. — K McNeil

Second Stage	Date	Time
Full dilatation at:	05 Feb 2010	1245h
Active pushing started:	05 Feb 2010	1248h

If applicable: ☐ Foley removed at _____ h.

(MD)/RM notified at 1246 h. Arrived at 1250 h.

FHR Mode: ☑ IA ☐ Ext. EFM ☐ Int. EFM

Time	1250	1253	1256	1258	1301	1303	1306	1309	1312	1314	1317
FHR	136	128	124	124	124	132	128	124	120	124	116
Time	1321	1323									
FHR	90*	90*									
Time											
FHR											
Time											
FHR											

1321h - FHR to 90 BPM after contraction, not recovering to baseline. Assisted to (L) lateral position - encouraged to push with next contraction — K McNeil RN

1323h - FHR remains at 90 BPM following contraction, head remains on perineum. For vacuum assisted delivery K McNeil RN

1325h - Straight catheterization by Dr. Owen for 100 cc clear urine. Vacuum applied by Dr. Owen — K McNeil RN

Vaginal Birth

Mother's position for delivery: ☐ Semi-sitting ☑ Side-lying ☐ Squatting ☐ Supine ☐ Other _____

Delivery of: ☐ Male ☑ Female @ 1327 h by ☐ SVD ☑ Vacuum* ☐ Forceps*

Oxytocin: 5 units given ☐ IM ☑ IV with ☑ anterior shoulder ☐ before placenta ☐ after placenta delivered

☐ Not given Reason: _____

Attending staff NRP trained: ☑ Yes ☐ No

Resus Team/MD/RT called for delivery: ☐ Yes ☑ No Indication: _____

1327h - Vacuum assisted birth - required one pull and had Ø pop-offs. Vacuum removed after birth. - K McNeil RN

Initial Mother-Baby Contact

☑ Skin-to-skin contact Time: 1327 h Duration: 42" (all babies for at least 30-60 minutes immediately after birth)

☑ Baby latched to breast Time: 1340 h Describe: baby-led, latch is satisfactory

☐ None of above: Reason _____

Fourth Stage: Postpartum Assessments

Time	1345h	1405h	1425h	1445h	1515h	1545h			
B/P	120/68	118/74	118/76	120/70	122/74	118/76			
Pulse	80	84	80	76	76	80			
Temp				37.2					
Lochia	scant rubra	mod rubra	mod rubra	mod rubra	scant rubra	mod rubra			
Perineum	small 1° tear	sm swelling	swollen ice pack on	ice pack	ice pack	ice pack			
Fundus	firm 2cm ↓ ⊙	firm 2 ↓ Umb	firm 2 ↓ Umb	firm 1 ↓ ⊙	firm 1 ↓ ⊙	firm 1 ↓ Umb			
Voiding				up to BR spont. void					
Initials	KM	KM	KM	KM	KM	KM			

Epidural Catheter removed intact by N/A Date/Time:

✓Tub/Shower Bed bath Mother/ Infant to Room # 806 Date/Time: 05 Feb 2010 @ 1550h via: ✓Wheelchair Stretcher

Infant transferred to nursery: Yes ✓No Comments:

1400h Baby latched successfully unassisted x2 — KM McNeil RN

Key (for any variance * see Progress Notes)

Fetal Health Surveillance:

Rate: mean FHR

Mode:
- **IA** = intermittent auscultation
- **E** = external EFM
- **S** = spiral/internal EFM

Accelerations
IA:
- ✓ = heard
- Ø = not heard

EFM:
- ✓ = present
- Ø = absent*

Decelerations
IA:
- ✓ = heard*
- Ø = not heard

EFM:
- Ø = absent
- **E** = early*
- **V** = variable*
- **L** = late*
- **P** = prolonged*

Rhythm (IA)
- **R** = regular
- **I** = irregular

Variability (EFM):
- Ø = absent* (undetectable)
- ↓ = minimal (≤ 5 bpm)
- \+ = moderate (6 - 25 bpm)
- ↑ = marked (> 25 bpm)

Classification:
- **N** = normal
- **Atyp** = atypical
- **Abn** = abnormal

Contractions:
Intensity:
- **M** = mild
- **Mod** = moderate
- **S** = strong
- ____ mmHg (IUPC)

Resting Tone:
- **So** = soft
- **F** = firm
- ____ mmHg (IUPC)

* See companion document for recommended charting details.

Maternal Assessment:

Emotional Status:
- **Ax** = anxious
- **Cl** = calm
- **CW** = coping well
- **D** = difficulty managing
- **Ex** = exhausted
- **P** = panicky
- **S** = sleeping

Activity:
- **Amb** = ambulating
- **BB** = birthing ball
- **C** = chair
- **RL** = right lateral
- **LL** = left lateral
- **Su** = supine
- **Li** = lithotomy
- **Tr** = Trendelenberg
- **HK** = hands & knees
- **KC** = knee-chest
- **SF** = semi-Fowler's
- **Sq** = squatting
- **WL** = wedge under left
- **WR** = wedge under right

Supportive Care measures:
- **At** = aromatherapy
- **CC** = cool compresses
- **CP** = counterpressure
- **Fl** = fluids
- **IP** = ice pack
- **M** = massage
- **Mu** = music
- **Rf** = reflexology
- **Sh** = shower
- **T** = tub / whirlpool
- **TE** = TENS
- **Pc** = pericare
- **WC** = warm compresses
- **Oth** = other

Regional Analgesia:
- **R/L sensory** = right/left sensory level testing
- **R/L motor** = right/left motor block

- **0** = none
- **1** = partial
- **2** = almost complete
- **3** = complete

Effect:
- **E** = effective
- **P** = partially effective
- **I** = ineffective

Sedation:
- **0** = alert
- **1** = sometimes drowsy / easily roused
- **2** = often drowsy / easily roused
- **3** = often drowsy / difficult to rouse
- **S** = asleep / stirs to touch

Partogram Practice Scenario – Sarah and John

At 0830h Sarah arrives in your Labour and Birth Unit, accompanied by her partner John. She tells you she had a 'gush' of clear fluid at 0730h this morning, and has been having contractions since 0500h.

Sarah's contractions are every 3 to 5 minutes, last approximately 45 seconds and are mild to palpation with the uterus relaxing between. Her pad reveals a moderate amount of clear fluid tinged with scant pink show. The fluid is positive for ferning. She is able to talk through her contractions and although she says the contractions are painful, she is much more comfortable when either walking or sitting in the rocker. She's 'feeling nervous' about labour but feels reassured since coming to hospital.

Sarah hands you her prenatal record. This is her second pregnancy; she and John experienced a spontaneous loss two years ago. Her LMP was 28 April. The 2nd trimester u/s and dates confirmed her EDD to be 02 February, making her 40+3/7 today. She is A positive with a negative antibody screen and her GBS screen was negative 4 weeks ago. You talk with her about her Birth Plan. She tells you she is frightened about the pain, about having an epidural, and is worried about how she will cope. She wants to know that someone will be available to her and will 'look after' her. You reassure her, talk about the nurse's role and her options for pain relief.

You check her vitals signs and the baby's heart rate by auscultation. You palpate her abdomen and feel confident the baby is engaged with a cephalic presentation. You reassure them that both Sarah and their baby are well and that she appears to be in early labour, and discuss how labour progresses. You recommend they continue to walk around and allow the contractions to become more regular and stronger before you examine her cervix. You review some basic comfort measures and encourage them to come to you with any questions or concerns. It is now 0900h. You contact her Family Doctor (Dr. Jones) to give report.
At 0945h, John returns and says "Sarah needs you". Sarah is now breathing with contractions and looks tense. John has been massaging her lower back. You reassess her and the baby: 122/84, T36.8 P88, R22; FHR 128 (IA) with an acceleration heard. You examine her cervix and determine she is 4 cm dilated, 100% effaced, Station 0. The baby's position is OP. You determine she is now in active labour and begin using the partogram.

You offer suggestions for comfort and Sarah decides she would like to try labouring in the shower. You move a birthing ball into the shower so she can sit if she likes, and, using IA every 15 minutes, assess the FHR to be 136, 140, 132, 128, bpm with regular rhythm, accelerations heard and no decelerations.

Sarah sits in the shower until 1100 or so. She found this an effective way to cope with her contractions but she wants to use the washroom, have a drink and change her position. She sits backwards in a chair, leaning forward as she focuses on each contraction. You continue to monitor her FHR by auscultation Q 15 minutes. (136, 154, 132, 140, 144) Accelerations are audible. Contractions are moderate occurring q 2-4 minutes, lasting 40-50 seconds. Her BP is 130/80.

At 1210h Sarah is tearful, wants to lie on her bed, and requests 'something for the pain'. She is having more difficulty focusing on breathing during contractions. Dr. Jones arrives at 1225 and examines her cervix which is 4-5 cm dilated, Stn (0) and the baby's position remains OP. You discuss options for pain relief and she decides to try fentanyl. You initiate a saline lock and administer fentanyl. (Her weight is 75 Kg - dose 1 mcg/Kg IV) The plan is to reassess her cervix in 1 hour to check for progress. The FHR remains normal at 134, 140, 132, and 130. She receives a second dose of fentanyl at 1300 with good effect.

Over the next hour, contractions have decreased slightly to q 4-5 minutes x 45 seconds. You check her cervix and it remains unchanged. The team (Sarah, John, Dr. Jones and you) discuss a plan. The obstetrician is consulted and oxytocin augmentation is initiated at 0.5 mU/min.

By 1515, strong contractions are occurring q2 – 3 minutes, lasting 60 seconds. The oxytocin infusion has been increased q 30 minutes to 2 mU/min. The EFM tracing is normal with baseline 145 bpm, average variability, accelerations to 170 BPM with irregular and infrequent mild variable decelerations to 110 bpm, lasting 10 – 15 seconds. Sarah has been coping very well with labour with supportive measures including massage, cold compresses, and encouragement from you and John. Her cervix is now 6 cm dilated, station +1, fetal position OP. You talk about some next steps and after discussion, she decides on an epidural. You make arrangements and assist her into position. The anesthetist completes the procedure at 1555. Her blood pressure prior to the start was 144/84. You check her BP q5 minutes x 2 and q15 minutes for an hour after the epidural is in place. (140/80, 136/88. 130/80, 134/84, 128/80, 136/88). The epidural is effective with good pain relief and Sarah is able to easily move from side to side. When she is more comfortable, you discuss what to expect in second stage and encourage a more upright position.

By 1630, the FHR baseline has increased to 170 bpm. Variability has been minimal for the last hour. Within the last 20 minutes you note that there have been 3 variable decelerations that have been progressively deepening to 90 bpm, lasting 45-60 seconds. You encourage Sarah to change position from side to side. The tracing improves and then is followed at 1640 by a deceleration to 90 bpm x 2 ½ minutes. You discontinue the oxytocin. Sarah complains of pressure and feels an urge to push with ++ blood show. A vaginal examination reveals full dilatation, with the fetal head rotating to LOA and station +2. You encourage Sarah to bear down with contractions as she feels the pressure mount.

The FHR returns to a baseline of 155 bpm. By 1720 Sarah is experiencing a strong urge to push. She follows her body's urge with further descent of the fetal head noted. You lower the bottom of the birthing bed, and Sarah rests her feet on this as she sits on the edge of the upper part of the bed. Her family doctor arrives to attend the birth.

Sarah delivers spontaneously a male (Jordan) at 1752. You administer oxytocin 5 units IV. Jordan cries spontaneously and is placed skin-to-skin on Sarah's chest. Blood loss is initially heavy, uterus boggy and 3 large clots are expressed. Dr. Jones administers 1000 µg of misoprostol per rectum. An IV is started with 40 IU of oxytocin, running at 250/hr. Sarah's V/S remain normal and the bleeding settles within 30 minutes. Jordan self attaches at the breast and nurses well at 1830.

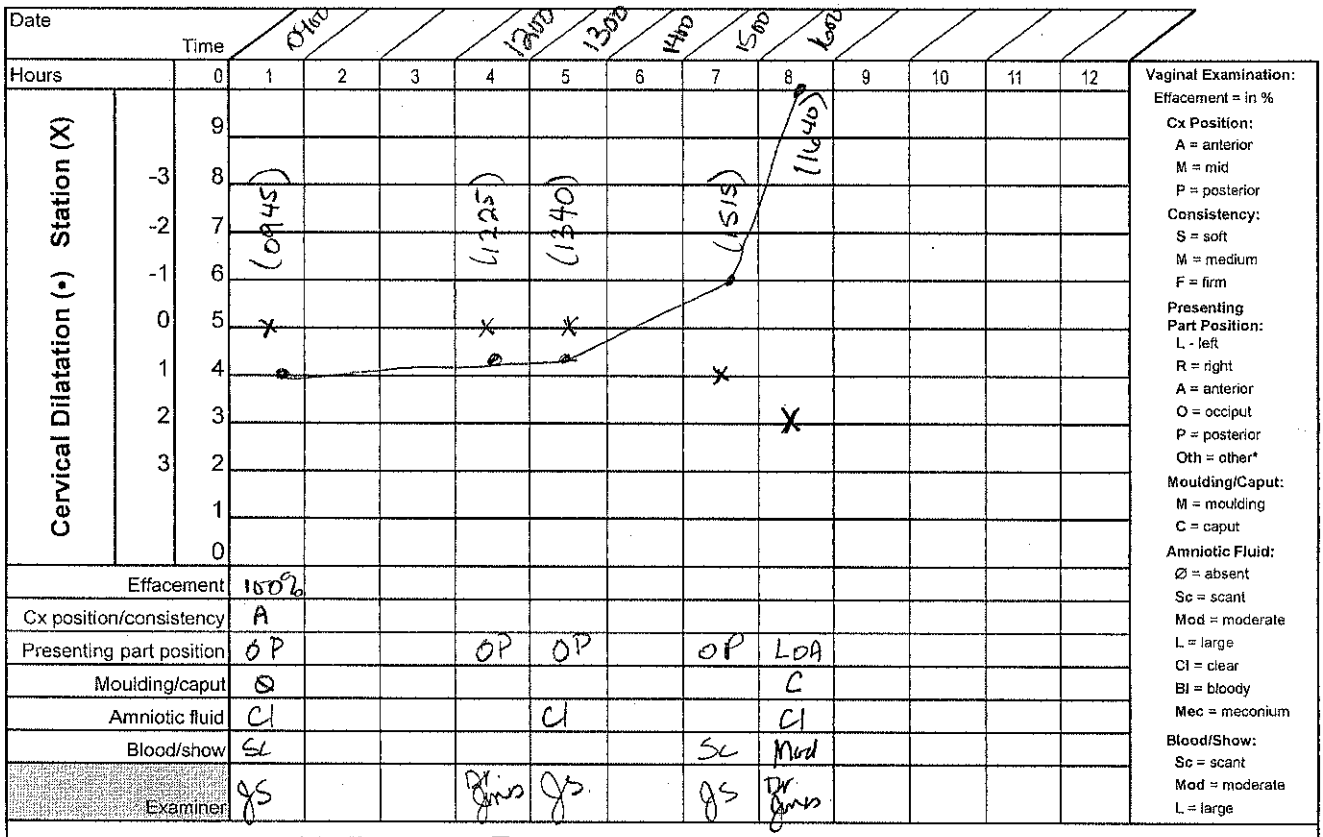
Please refer to the Labour Partogram on the next pages to see an example of how it might be completed using the above Practice Scenario.

Labour Partogram

Sarah Brown (label)

G: 2 P: 0 Gest: 40 3/7 wks Allergies: none known
Blood group/Rh: A+ Antibodies: negative
Date/time active labour established: Feb 5, 2010 0945
☑ SRM ☐ ARM Date, time, describe fluid: Feb 5 @ 0730 / clear
GBS: ☐ positive ☑ negative ☐ unknown

Birth Plan: anxious about pain, epidural Support person(s): John - husband
Risk factors/concerns: healthy, uncomplicated pregnancy



	0	1	2	3	4	5	6	7	8	9	10	11	12
Effacement		100%											
Cx position/consistency		A											
Presenting part position		OP			OP	OP		OP	LOA				
Moulding/caput		0							C				
Amniotic fluid		Cl				Cl			Cl				
Blood/show		SL						SL	Mod				
Examiner		gs			gs	gs		gs	Dr gs				

Vaginal Examination:
Effacement = in %
Cx Position:
A = anterior
M = mid
P = posterior
Consistency:
S = soft
M = medium
F = firm
Presenting Part Position:
L - left
R = right
A = anterior
O = occiput
P = posterior
Oth = other*
Moulding/Caput:
M = moulding
C = caput
Amniotic Fluid:
Ø = absent
Sc = scant
Mod = moderate
L = large
Cl = clear
Bl = bloody
Mec = meconium
Blood/Show:
Sc = scant
Mod = moderate
L = large

Medications (☐ See separate Medication Administration Record)

Include time, medication name, dose, route, and initials (e.g. antibiotics, narcotics)					
		1235 Fentanyl 75 mcg IV gs	1300 Fentanyl 75 mcg IV MS		

Patient and Family Teaching

TOPIC	INITIALS		TOPIC	INITIALS		TOPIC	INITIALS	
Labour Progress	gs		Induction/Augmentation	gs		Second Stage of Labour	gs	
Breathing/Relaxation Techniques	gs		Birth Plan	gs		Cesarean Birth		
Positioning for Labour and Birth	gs		Pain Relief Options	gs		Preterm Birth		
Grief Counseling			Breastfeeding	gs		Other (describe)		

Partogram #1 of 1

Maternal & Fetal Assessments

SARAH Brown
(label)

Date																															
	Time				0745	1000	1030	1045	1100	1115	1130	1145	1200	1215	1230	1245	1300	1315	1330	1345	1400	1415	1430	1445								
Fetal Health Surveillance	Rate				128	136	140	132	128	136	154	132	140	144	134	140	132	130	128	154	148	144	150	155	155							
	Mode				IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	IA	E	E	E							
	Accelerations				✓	✓	○	✓	✓	✓	✓	○	✓	✓	○	✓	✓	✓	○	✓	✓	✓	✓	✓	✓							
	Decelerations				○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○	○							
	Rhythm (IA)				R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	–	–	–							
	Variability (EFM)																					+	+	+							
	Classification				N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N	N							
Contractions	Frequency				q3-4	q3-4	q3-4	q3-4		q2-4		q2-4	q2-4		q3-5	q4-5		q5			q4-5		q2-3								
	Duration				30-40 sec	30-40 sec	30-50 sec			40-50 sec		40-50 sec	40-50 sec		40-50 sec	45 sec		40-45 sec			40-50		50-60 sec								
	Intensity				mod	mod	mod			mod		mod	mod		mild-mod	mod		mild-mod			mod		mod-st.								
	Resting tone				So	So	So			So		So	So		So	So		So			So		So								
Oxytocin rate (mU/minute) ☑ Augmentation ☐ Induction started at 1355 h.																					0.5	0.5	1	1							
Maternal Assessment	Blood pressure				122/84							130/86									134/80										
	TPR				36.8-88-22															36.6-92-A											
	O_2 Saturation																														
	Emotional Status				Ax	CW		CW		CW		CW	D		CW	CW		CW		CW	CW		D								
	Activity				Amb	C		C		C		C	LL		LL	C		LL			C		C								
	Supportive Care				m	Sh		Sh		CP FI		CP m	WC		WC FI	IP		CC m			CC		CC								
Regional Analgesia	☐ Epidural ☐ Spinal ☐ Combined ☐ PCEA Bolus at _____ h. Continuous infusion at _____ h.																														
	Dr.																														
	Bolus/Rate																														
	R/L Sensory																														
	R/L Motor																														
	Effect/ Sedation																														
	Pt. Position																														
Initials					RS	RS	RS	RS		RS	QS	QS	RS	RS	QS	MS	MS	MS													

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Partogram #1 of 1

Sarah Brown (label)

Section	Item	1500	1515	1530	1545	1600	1615	1630	1645	1700	1715		
Fetal Health Surveillance	Rate	140	145	150	150	155	160	170	170	160	155		
	Mode	E	E	E	E	E	E	E	E	E	E		
	Accelerations	✓	✓	✓	⊘	✓	⊘	⊘	⊘	✓	✓		
	Decelerations	⊘	V	V	⊘	V	V	V	P	V	V		
	Rhythm (IA)												
	Variability (EFM)	+	+	↓	↓	↓	↓	↓	+	+	↓		
	Classification	N	Aty	N	N	N	N	Abn	Abn	Aty	aty		
Contractions	Frequency	q2-3		q2-3		q2		q2		q2-3			
	Duration	60sec		60		60		60-70		60sec			
	Intensity	S		S		S		S		S			
	Resting tone	So		So		So		So		So			
Oxytocin rate (mU/minute) ☐ Augmentation ☐ Induction started at ______ h.		2	2	2	2	2	2	D/C 0	/	/	/		
Maternal Assessment	Blood pressure	130/80		144/84	140/80	136/88	130/80	134/84	128/60	136/88			
	TPR							37.4-88-16					
	O_2 Saturation												
	Emotional Status	CW		CW		CW		D		CW		CW	
	Activity	RL		Sitting		LL		RL		LL		SF	
	Supportive Care	CC								Oth			
Regional Analgesia (Dr. DR. Logan)	Bolus/Rate					6ml/hr		6		6		6	
	R/L Sensory					T10		T10		T10		T10	
	R/L Motor					0		0		0		0	
	Effect/ Sedation					P		E		E		E	
	Pt. Position												
Initials		[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]		

Date

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Printed name	Signature/Status	Initials
JANE SMITH	J Smith RN	JS
Mary Stuart	M Stuart RN	MS

Date & Time	Progress Notes
Feb 5/10 0945	Sarah has been walking c contractions. C/o backache and feeling much more uncomfortable. Reassurance and support given. Assisted to sit in the shower. – J Smith RN
1225	Dr. Jones discussed labour progress c Sarah and John. Plan is to provide analgesic and reassess progress in 1 hour. ——— J Smith, RN
1315	Assisted to BR to void and settled in chair. Medication effective ——— M Stuart
1520	FHR baseline 145 bpm c occasional variable decelerations to 110 bpm x 10-15 seconds. Quick return to baseline. Sarah coping well c labour c coaching and support through each contraction. Requesting epidural.
1530	Many occasional variable decelerations. Will continue to monitor. In and out catheterization ——— J. Smith RN
1630	Repetitive variables from baseline (170 bpm) to 90 bpm x 45-60 secs. Sarah repositioned c effect. Dr. Jones notified. – J. Smith
1640	Prolonged decelerations x 2½ minutes to 90 bpm. Sarah notes ++ pressure and urge to push. – J Smith
1700	Feeling of pressure increasing. Sarah sitting upright c pillows supporting her. Variable decelerations continue c most contractions from baseline (166 bpm) to 110 bpm x 15-30 seconds. Caput progressing. ——— J. Smith RN

Second Stage	Date	Time
Full dilatation at:	Feb. 5/10	1640
Active pushing started:	Feb 5/10	1720

If applicable: ☐ Foley removed at _____ h.

MD/RM notified at 1745 h. Arrived at 1750 h.

FHR Mode: ☐ IA ☐ Ext. EFM ☐ Int. EFM

Sarah Brown (label)

Time	1720	1725	1730	1735	1740	1745	1750				
FHR	155	160	145	155	150	130	135				
Time											
FHR											
Time											
FHR											
Time											
FHR											

1730 Fetal head progressing well as Sarah pushes & contractions. Mild variable decelerations continue. Baseline normal & average variability. J Smith RN

Vaginal Birth

Mother's position for delivery: ☑ Semi-sitting ☐ Side-lying ☐ Squatting ☐ Supine ☐ Other _____

Delivery of: ☑ Male ☐ Female @ 1752 h by ☑ SVD ☐ Vacuum* ☐ Forceps*

Oxytocin: 10 units given ☑ IM ☐ IV with ☑ anterior shoulder ☐ before placenta ☐ after placenta delivered

☐ Not given Reason: _____

Attending staff NRP trained: ☑ Yes ☐ No

Resus Team/MD/RT called for delivery: ☐ Yes ☑ No Indication: _____

Baby cried spontaneously at birth. Alert and rooting at Mom's breast.

Initial Mother-Baby Contact

☑ Skin-to-skin contact Time: 1752 h Duration: 90 min (all babies for at least 30-60 minutes immediately after birth)

☑ Baby latched to breast Time: 1830 h Describe: Baby self-attached at breast. Nursed well.

☐ None of above: Reason _____

SARAH BROWN
(label)

Fourth Stage: Postpartum Assessments

Time	1800	1810	1820	1840	1905	1930	2015.	2100.	
B/P	130/80	134/84	130/76	144/80	134/84	130/80	134/80	134/76.	
Pulse	92	88	96	90	88	84	84	88	
Temp							37².		
Lochia	sm	mod	mod clots +3.	sm	sm	sm	sm	sm	
Perineum	✓	✓	✓	ice					
Fundus	Fe ⊙	1FO boggy	1FO massage	firm	firm ⊙	firm	firm	firm	
Voiding							large amt.		
Initials									

☑ Epidural Catheter removed intact by J Jones Date/Time: Feb. 5 at 2020.

☐ Tub/Shower ☐ Bed bath Mother/ Infant to Room # 520 Date/Time: Feb 5 at 2050 via: ☑ Wheelchair ☐ Stretcher

Infant transferred to nursery: ☐ Yes ☐ No Comments: 1820 Flow mod ē several clots expressed. Dtion of blood ē massage. 1000 mg misoprostol given PR by Dr. Jones IV - 40 u oxytocin 1/500 RTL running at 250/hr 1845 Flow settled.

Key (for any variance * see Progress Notes)

Fetal Health Surveillance:

Rate: mean FHR

Mode:
- IA = intermittent auscultation
- E = external EFM
- S = spiral/internal EFM

Accelerations
IA:
- ✓ = heard
- Ø = not heard

EFM:
- ✓ = present
- Ø = absent*

Decelerations
IA:
- ✓ = heard*
- Ø = not heard

EFM:
- Ø = absent
- E = early*
- V = variable*
- L = late*
- P = prolonged*

Rhythm (IA)
- R = regular
- I = irregular

Variability (EFM):
- Ø = absent* (undetectable)
- ↓ = minimal (≤ 5 bpm)
- + = moderate (6 - 25 bpm)
- ↑ = marked (> 25 bpm)

Classification:
- N = normal
- Atyp = atypical
- Abn = abnormal

Contractions:
Intensity:
- M = mild
- Mod = moderate
- S = strong
- ____ mmHg (IUPC)

Resting Tone:
- So = soft
- F = firm
- ____ mmHg (IUPC)

* See companion document for recommended charting details.

Maternal Assessment:

Emotional Status:
- Ax = anxious
- Cl = calm
- CW = coping well
- D = difficulty managing
- Ex = exhausted
- P = panicky
- S = sleeping

Activity:
- Amb = ambulating
- BB = birthing ball
- C = chair
- RL = right lateral
- LL = left lateral
- Su = supine
- Li = lithotomy
- Tr = Trendelenberg
- HK = hands & knees
- KC = knee-chest
- SF = semi-Fowler's
- Sq = squatting
- WL = wedge under left
- WR = wedge under right

Supportive Care measures:
- At = aromatherapy
- CC = cool compresses
- CP = counterpressure
- Fl = fluids
- IP = ice pack
- M = massage
- Mu = music
- Rf = reflexology
- Sh = shower
- T = tub / whirlpool
- TE = TENS
- Pc = pericare
- WC = warm compresses
- Oth = other

Regional Analgesia:

R/L sensory = right/left sensory level testing

R/L motor = right/left motor block

- 0 = none
- 1 = partial
- 2 = almost complete
- 3 = complete

Effect:
- E = effective
- P = partially effective
- I = ineffective

Sedation:
- 0 = alert
- 1 = sometimes drowsy / easily roused
- 2 = often drowsy / easily roused
- 3 = often drowsy / difficult to rouse
- S = asleep / stirs to touch