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User Guide:

Nova Scotia Labour Partogram

Revised: July 2024

This document is written using some gendered terms as RCP transitions forms and communication to incorporate inclusive language. The Program's intent is to advocate for the entire perinatal population, regardless of gender identification. The RCP encourages healthcare professionals to engage in respectful conversation with patients regarding their gender identity and their preferred pronouns, and to apply RCP guidelines as appropriate to meet each person's needs.

Introduction

The Nova Scotia Labour Partogram (RCP 03) has been 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 to provide a guide for evidence-based intrapartum care. Additionally, specific information in the Partogram is collected for the Nova Scotia Atlee Perinatal Database (NSAPD), which includes data collection from all Provincial Perinatal Forms. These data are collected, analyzed, and disseminated across Nova Scotia to inform the monitoring of provincial perinatal outcomes and to improve health care planning and provision.

Guiding Principles

The Partogram is designed for use in conjunction with the NS Prenatal Record, the 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 birthing facilities offering different levels of perinatal care
- Be usable from labour admission through birth to beginning of 4th stage
- Incorporate evidence-informed recommendations for intrapartum assessment, interpretation of findings, and interventions
- Minimize duplicate documentation 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

- RCP form 02 provides the admission history and complements documentation on the Partogram.

- There are two key components for documentation of intrapartum assessments:
  i. the labour curve (i.e. on page one), and
  ii. surveillance of the labouring woman/person and the fetus (pages two & three, and five [second stage])

  Recommendations for this surveillance require health professionals to document more frequently than is required for recording the vaginal/cervical assessments on the labour curve

- When patient is admitted:
  1. For assessment of latent labour you may *choose* to initiate the Partogram, unless assessment findings are documented elsewhere on the health record (e.g. Progress Notes). Labour onset can be difficult to diagnose and is often done retrospectively; this requires assessment and documentation of uterine activity and cervical status. **The first stage of labour includes both the latent and active phases**. According to the Society of Obstetricians and Gynaecologists of Canada (SOGC 2019):

Labour: first stage	Regular uterine contractions accompanied by cervical dilatation and/or effacement. The first stage of labour includes the latent and active phases.
Latent phase	Presence of uterine activity resulting in progressive effacement and dilatation of the cervix proceeding to active phase. It is complete when a nulliparous woman reaches 4 cm dilatation and a parous woman reaches 4 to 5 cm. Cervical length is generally less than 1 cm.
Active phase	Presence of a pattern of contractions leading to cervical effacement and dilatation at 4 cm or greater in a nulliparous woman or 4 to 5 cm dilatation in a parous woman.

     Additionally, uterine activity affects fetal oxygenation, the degree to which depends on maternal, fetal, and uteroplacental factors affecting gas exchange. It is recommended that fetal well-being be assessed at least hourly in the latent phase of labour if admitted to the birthing area (SOGC 2020). The details required for documentation are described in the Fetal Health Surveillance section of this guide.

  2. For ongoing assessment and/or management of the fetus and woman/patient in active labour, the Partogram should be initiated.

  3. 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 patient
  - Reviewing:
    - The Nova Scotia Prenatal Record
    - Other relevant medical documentation (e.g. ultrasound or consultant reports)

- Perform a 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:
  - Additional information is to be documented in the Progress Notes, including
    - Any interventions performed in response to the variance (e.g. positioning, medication administration, comfort measures, etc.)

    - Communication with the most responsible care provider (MRP) or other members of the care team, including:
        - Exact time of notification
        - Nature of communication
        - Response from the MRP (or other team member)
        - Follow-up actions or changes to the plan of care
    - Evaluation of the clinical response to any corrective actions taken

- A blank space indicates that the action or assessment was not performed.
- When more than one 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 Partogram. This may be placed separately in the permanent health record. Cervical assessment typically occurs much less frequently than other assessments in labour so you may find it unnecessary to always have the labour curve present and available.

The following pages provide descriptive information for documentation on the Partogram

- Under the 'item' column, fields collected in the database 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 patient's admission history, labour, and birth plan
- Complements information found on the Nova Scotia Prenatal Record and the Maternal Assessment

Item	Description
Label area	Includes standardized demographic information.
The terms: 'gravida', 'term', 'preterm', 'abortus', 'living children', & 'stillbirth' (GTPALS) are defined below and have been adopted on the NS PNR to align documentation with terms used nationally. The GTPALS system provides more detail about the obstetrical history. For example, if a first-time pregnant person had twins at 35 weeks' gestation, they would be G1T0P1A0L2S0).	
*Gravida	The total number of pregnancies for the pregnant person, including this pregnancy, regardless of gestational age, type, or outcome. A pregnancy with twins/multiples is counted as one pregnancy. Note: An ectopic pregnancy, a missed abortion, a blighted ovum and a hydatidiform mole are classified as a gravida and should contribute to the total number of all pregnancies.
*Term	The total number of previous pregnancies with birth at ≥ 37 completed weeks. Note: A previous multiple pregnancy delivered at term should be counted as 1 term. If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as 1 term and 1 preterm.
*Preterm	The total number of previous pregnancies with birth occurring between 20+0 and 36+6 completed weeks. The absolute risk of recurrent spontaneous PTB is 30%. Late terminations should contribute to the total number of previous preterm pregnancies. Note: A previous multiple pregnancy delivered preterm should be counted as 1 preterm. If a previous multiple pregnancy resulted in one baby being delivered at term and another baby being delivered preterm, the pregnancy should be counted as 1 term and 1 preterm.
*Abortus	The total number of pregnancies that were spontaneous losses (before 20 weeks gestation or weighing < 500 grams) or planned terminations. Spontaneous abortions include miscarriage, ectopic pregnancy, missed abortion, blighted ovum and molar pregnancy.

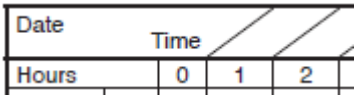
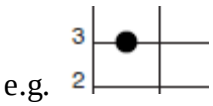
*Living Children	Number of children born to the pregnant person who are presently living.
*Stillbirth	Number of fetal deaths born to the pregnant person ≥ 20 weeks pregnancy OR if gestational age is not known, with a birth weight of ≥ 500 grams.
Gestation: _____ weeks*	Document gestational age as recorded on the Prenatal Record. “Best estimate” of gestational age is assessed using the guideline on the RCP website.
Blood group/Rh*	Document the patient’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 ≥4 cm dilated, in the presence of a regular pattern of uterine contractions.
Date/time of membrane rupture*	Document the date and time; further details are described on the Birth Record.
GBS (Group β streptococcus) status	Indicate whether results are positive, negative, or unknown.

Page 1: Key Background Information (cont'd)

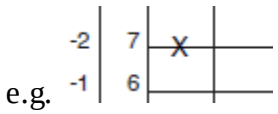
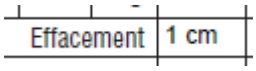
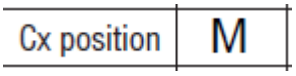
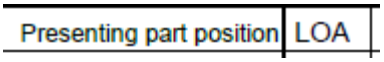
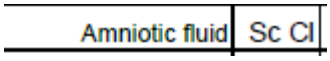
Item	Description
Birth Plan	Review and document the patient's plan for labour and birth (whether formally written or expressed verbally). Topic examples include role of support person(s); choice of comfort and pain relief methods; goals, plans, expectations, concerns, questions, and fears.
Support person(s)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

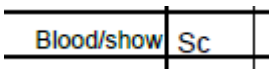
Page 1: Vaginal Examination

- The Labour Curve is a visual aid to document complete findings and assess progress in labour.

Item	Description
Date and time e.g. 	Record date and time. Begins at the hour of admission (e.g. the patient 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 e.g. 	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 labouring patient is examined at 0830h and the cervix is 3 cm dilated, place '•' in the middle (to denote the half hour mark) of the horizontal line indicating 3 cm. **When labour dystocia is suspected (dilatation of less than 0.5 cm/hr over 4 hours, OR no cervical change over 2 hours in the active first stage), further information about assessment, communication, and plan of care should be provided in the Progress Notes.*

Page 1: Vaginal Examination (cont'd)

Item	Description
Station e.g. 	Using 'X', document the descent of the presenting part (from -3 to +3) on the graph in the same column as the cervical dilatation. In the example shown to the left, the 'X' denotes station -2. **Hourly or more frequent assessment and documentation of station should continue during a passive second stage.*
Effacement e.g. 	Document cervical length in centimeters, or as % relative to complete effacement (100%)
Cx position e.g. 	Document the position of the cervix: A = anterior M = mid P = posterior
Presenting part position* e.g. 	Document the position of the presenting part (see page 29 for visual aid): L = left *or* R = right O = occiput *or* Oth = other* (describe in Progress Notes) A = anterior *or* P = posterior *or* T = transverse **Hourly or more frequent assessment and documentation of position should continue during a passive second stage.*
Moulding/caput	Document whether moulding or caput are present. If not, leave blank. If marked, describe in progress notes M = moulding C = caput
Amniotic fluid e.g. 	Document whether amniotic fluid is present per vagina; 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 e.g. 	Document whether blood or show is present per vagina; note appearance. If assessment findings are atypical, describe in progress notes: Sc = scant Mod = moderate L = large
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 the bottom of the page.

Page 1: Patient and Family Teaching

- Suggestions for teaching points to include during labour and birth; initial if discussed with patient, partner or family/support people. More than one care provider may provide teaching on any particular topic, and so space is provided for more than one set of initials.
- For all topics provide clear, concise information to help patients and families make informed decisions.

Topic	Description
Labour Progress	• Describe how labour starts; moving from latent 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; contractions generally become more regular, more frequent, stronger, and last longer. • Review expectations and discuss the average length of the active first stage of labour – i.e. 5 to 8 hours in nulliparous persons, and 4 to 5 ½ hours in multiparous persons. • 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 labouring patient to let you know if they experience new sensations. • Suggest how progress may be promoted through walking, upright positioning, and comfort and coping/relaxation techniques.
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 and hip squeeze, massage, use of ice or hot packs; remind them that not all techniques '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, use of peanut ball, leaning over birthing ball, sitting backwards in a chair, walking, swaying, etc. • Describe frequent position changes with use of labour support tools if the patient chooses epidural analgesia
Induction/Augmentation	• Discuss the indication for induction, or • Explain the rationale for augmentation (if indicated) in terms of labour progress • Review the chosen method of labour induction, what is involved 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
Birth Plan	• Encourage patient to talk about expectations for labour and birth to clarify misconceptions and to negotiate how you will provide support • Help patient identify what aspects of care/experiences are most important (Additional documentation may be indicated)
Pain Relief Options	• Discuss the patient's expectations for 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. • Provide reassurance of nurses' support during labour • Review three options for pharmacologic measures for pain relief (e.g. nitrous oxide, narcotics, and epidural) respecting the birth plan. Discuss the patient's preferences and provide information to ensure informed consent is given. For example, if the patient states they do not want to have an epidural, focus on other options/medications available. Include discussion of risks of medication including a possible effect on early breastfeeding. For more information please refer to: RCP's online clinical resources for supporting patients in labour (rcp.nshealth.ca)
Preterm Birth	• Inform the parents about additional team members who will be providing care for their baby, and facilitate introductions if possible.

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

Topic	Description
Second Stage of Labour	• Review expectations for the passive and active phase of second stage of labour and discuss the expected length of each – i.e. a passive second stage promotes passive descent and rotation of the fetal presenting part and is beneficial particularly when the presenting part is above station +1 or in a non-OA position and the urge to push is absent; length of passive stage varies based on parity, presence or absence of regional analgesia, fetal well-being, assessment progress, and overall clinical condition. • Describe how progress is determined throughout the passive and active second stage - by assessment of uterine activity; descent and position of the fetal presenting part; maternal sensation and urge to push; coping and pain control; and pushing effectiveness. • Discuss common sensations as second stage approaches and progresses; encourage patient to respond to their body's urge to push • Review positions of most comfort and effectiveness during second stage (e.g. sidelying position) • If pushing efforts become ineffective in one position, it is often helpful to assist the patient to move into another position to improve effectiveness of efforts.
Cesarean Birth	• Prepare patient and support person(s) for what they can expect to experience in the Operating Room and recovery area
Third Stage of Labour	• Discuss expectations during the third stage of labour and the immediate postpartum/postnatal period. • Describe interventions used to assist in the expulsion of the placenta to decrease or prevent blood loss • Describe interventions used to promote or enhance breastfeeding
Infant Feeding	• Explore patient's preferences for infant feeding, although provide information that recognizes breastfeeding as the optimal form of infant nutrition • Describe baby-led latch, cue-based frequency of feeding, positions • Review the possible effects of narcotics on early breastfeeding
Baby-Friendly Practices	• Review the benefits of early and regular skin-to-skin contact (for all babies). For more information, please refer to breastfeedingcanada.ca/en/baby-friendly-initiative/

Page 2/3: Page #_____ of _____

- If more than one Partogram is used during 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 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's 2020 Fetal Health Surveillance: Intrapartum Consensus Guideline.
- 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.
- The standard tracing paper speed is 3 centimeters per minute.
- **Variance(s) from normal findings are identified with an asterisk (*)** in the descriptions below. In the Progress Notes, document further details about assessments, actions taken and communication.

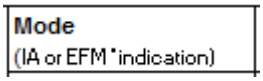
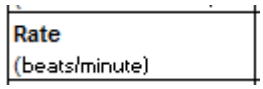
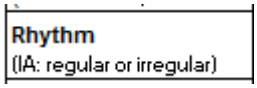
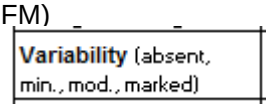
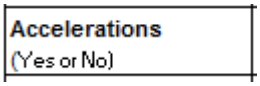
Table 23. Summary of recommended frequency of assessments and documentation

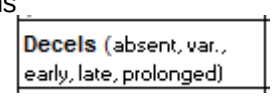
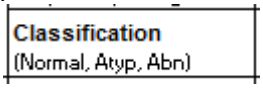
	IA FHS	EFM FHS	MHR[a]
Latent phase of labour if admitted to birthing area or individualized based on maternal fetal status if in triage or midwifery care at home (not admitted to hospital)	Q 1 hour	Q 1 hour	On admission and when determining baseline FHR
Active first and passive second stage	Q 15–30 minutes	Q 15 minutes	Q 4 hours with intact membranes OR Q 2 hours with ruptured membranes
Active second stage	Q 5 minutes	Q 15 minutes IF continuous tracing and caregiver continuously present[21]	Q 15–30 minutes[b]

[a] Additionally done any time there is uncertainty between the MHR and FHR and if intrauterine resuscitation is initiated.

[b] Consider a continuous tracing using tocodynamometer if available and document every 15 minutes.

EFM: electronic fetal monitoring; FHR: fetal heart rate; FHS: fetal health surveillance; IA: intermittent auscultation; MHR: maternal heart rate.

FHR Characteristic	Description
Date and time 	Record date and time of assessment. Times should be labeled in continuous 15-minute increments.
Mode 	Document fetal surveillance method used. Intermittent auscultation (IA) is the recommended method for healthy term intrapartum fetal surveillance in spontaneous labour. IA = Intermittent Auscultation EFM = Electronic Fetal Monitoring (*Document the indication for continuous EFM in Progress Notes, initially and/or any time there is a change between IA and EFM. The type of equipment used for assessment (Doppler, external ultrasound transducer, or internal fetal scalp electrode), should also be documented in the Progress Note.)
Rate 	Record baseline fetal heart rate (FHR) as a single number, as described by the SOGC (2020). The normal FHR is 110 – 160 bpm. If findings are outside this range, determine possible causes, respond as is appropriate and record in Progress Notes.
Rhythm (IA) 	Document the rhythm of the FHR when using IA: • Regular • Irregular
Variability (EFM) 	Document the variability of the FHR when using EFM: • Absent* (undetectable) • Minimal (≤ 5 bpm) • Moderate (6 – 25 bpm) • Marked (> 25 bpm)
Accelerations 	Document: Y = heard (IA) or present (EFM) N = not heard (IA) or absent (EFM) * With EFM, the presence of accelerations is a normal finding but is not necessary during labour to define a tracing as being normal. See the SOGC guideline for additional details to guide interpretation and response.

FHR Characteristic (continued)	Description
Decelerations 	**For IA**, document: N = Not heard Y* = Heard **For EFM**, Document: N = No decelerations present E = Early deceleration(s) present V* = Variable deceleration(s) present L* = Late deceleration(s) present P* = Prolonged deceleration(s) present *When decelerations are present on IA or EFM assessment, the Progress Notes should be used for further supporting documentation. Other terms used to describe decelerations may include periodic, episodic, repetitive, non-repetitive, recurrent, or intermittent. The frequency with which decelerations are documented should be guided by clinical judgment in consideration of the overall situation and clinical interpretation.
Classification 	Classify the FHR assessment as: • Normal • Atypical* (applicable to EFM only) • Abnormal* * Uterine activity needs to be considered in determining the overall classification when assessing FHS by IA. ** In the Progress Notes, document interpretation of the classification in light of the overall clinical picture (include maternal assessments), as well as responses/interventions, and communication with the most responsible provider and the perinatal team.

Page 2/3: Contractions

Information	Description
Frequency	Frequency is determined by counting the number of contractions in a 10-minute window, averaged over 30 minutes. Assessing frequency of uterine activity using a 10-minute window helps identify situations when tachysystole occurs (SOGC 2020). ** More than 5 contractions in a 10-minute window, averaged over a 30-minute period, is a characteristic of tachysystole. Mode of assessment of uterine activity, further assessment, interpretation, and response should be documented in the Progress Notes.*
Duration	Document the length of time in seconds the contraction lasts, from beginning to end (i.e. 45 – 60 sec). ** Contraction duration greater than 90 seconds, including coupling or tripling with an overall duration greater than 90 seconds before reaching full resting tone, is a characteristic of tachysystole. Further assessment, interpretation, and response should be documented in the Progress Notes.*
Intensity	Document the strength of contractions determined by fundal palpation (IA or EFM): M = mild Mod = moderate S = strong If using an Intrauterine Pressure Catheter (IUPC), document the value recorded ____ mmHg. **Contraction intensity measured at greater than 75 mmHg using an IUPC is a characteristic of tachysystole. Further assessment, interpretation, and response should be documented in the Progress Notes.* *Montevideo Unit calculations (with IUPC) should be completed every 30 minutes and documented in the Progress Notes.*

Information (continued)	Description
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. **Absence of resting tone that lasts for a minimum of 30 seconds, or reaches 20-25mmHg using IUPC, is a characteristic of tachysystole. Further assessment, interpretation, and response should be documented in the Progress Notes.*

Page 2/3: Oxytocin Dose

- Document the time that the infusion is initiated.
- Document the dose being infused in milliunits 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 dose (milliunits/min) in the appropriate columns that correspond with the time of any dose changes including initiation, increase, decrease, and cessation of the infusion.
- **Oxytocin is considered a High Alert medication**; space is provided for the initials of the health professional who has conducted an independent double check.

Page 2/3: Ongoing Assessment

Information	Description
Fresh Eyes	Once active labour is established, a second health professional who is competent in fetal health surveillance and interpretation in labour will assess and interpret the EFM tracing every 60 minutes. If they agree with the interpretation of the tracing, they initial here. Initials should be paired with the printed name, signature and status of the recorder on page 1 of the Partogram. If there is a disagreement with the interpretation of the tracing, the second health professional places their initials and an asterisk (*) in the appropriate space, then documents their interpretation and actions taken in the Progress Notes. Refer to the Fetal Health Surveillance: 'Fresh Eyes' Approach Policy (Nova Scotia Health).
Blood pressure	Document systolic and diastolic blood pressure and time in the appropriate column that corresponds with the time of assessment. If findings are atypical, indicate with * and describe further assessment and interventions (if applicable) in Progress Notes. The SOGC recommends the following approach to blood pressure monitoring: "1. BP should be measured with the patient 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 that have not been validated for use in preeclampsia may under- or over-estimate BP in these women and comparison of readings using mercury sphygmomanometry or a calibrated aneroid device is recommended." If the patient is in a side-lying position, assess the BP using the lower (dependent) arm.

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

Information	Description

Temperature, Pulse, Respirations	Document the labouring patient's temperature, pulse and respiratory rate (e.g. 37^3 – 88 – 22) in the appropriate time columns.
	
	The minimum frequency with which the labouring patient's heart rate should be assessed and documented:
	• Latent labour: on admission and when determining baseline FHR
	• Active first and passive second stage labour:
	  ○ Q 4 hours (intact membranes)
	  ○ Q 2 hours (ruptured membranes)
	• Active second stage labour:
	  ○ Q 15 – 30 minutes
	• Any time there is a need to distinguish between maternal and fetal heart rate.
	
	If findings are atypical, indicate with * and describe further assessment, interventions, and response (if applicable) in Progress Notes.

Oxygen 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.
Somnolence Score For more detailed information please refer to RCP's clinical resource *Working with Pain in Labour*	For labouring patients who have received medications that may suppress respiratory efforts: 1 = awake and alert: *no action needed* 2 = sedated but arousable: *no action needed* 3 = heavily sedated and difficult to arouse, drifts off during conversation: *requires action/decrease dose* 4 = unresponsive or somnolent, minimal or no response to physical stimulation: *unacceptable, stop opioid, consider administering Naloxone*
Patient Position	Document the position of the labouring patient using free text. Consider position changes for comfort, to evenly distribute regional medications (if applicable) or to enhance labour progress.
Other (e.g. glucose, reflexes)	Indicate what is being assessed and complete as needed for patient's clinical monitoring.

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

Information	Description
Bladder assessment	Assess bladder status at least every 2 hours and encourage the patient to void as the bladder fills. If they are unable to void, intermittent catheterization may be needed to keep the bladder empty (AWHONN 2017). Document assessment findings and actions (if taken).

Page 2/3: Regional Analgesia

Information	Description
Epidural, Spinal, Combined, PCEA	Indicate the type of regional analgesic used: Epidural Spinal Combined PCEA (Patient controlled epidural analgesia)
Bolus at _____ h.	Document the time the regional analgesia initial bolus was administered.
Continuous infusion at _____ h.	Document the time at which the continuous infusion of regional analgesia was commenced.
Dr.	Document the name of the anaesthesiologist who initiated the regional analgesia and/or who is providing ongoing care.
Bolus (PCEA)	Document when a bolus of regional analgesic has been administered by the anaesthesiologist (or delegate), or the rate of continuous infusion, or in accordance with local policy or practice.

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

<table>
<tr><th>Information</th><th>Description</th></tr>
<tr><td>Dermatome at or below T4</td><td>Testing with ice/alcohol swab for sensation, indicate the dermatome level at which normal sensation is no longer felt, confirming this is no higher than Level T4.

<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>
Dermatome levels higher than T4 should be reported to the anaesthesiologist in accordance with institutional practice and/or policies. If the patient is receiving a continuous epidural infusion, stop infusion and notify the anaesthesiologist in accordance with institutional practice and /or policies.</td></tr>
<tr><td>Bromage 4-6</td><td>Assess and document every hour:

<table><tr><th>Score</th><th>Criteria</th></tr><tr><td>1</td><td>Complete block (unable to move feet or knees)</td></tr><tr><td>2</td><td>Almost complete block (able to move feet only)</td></tr><tr><td>3</td><td>Partial block (just able to move knees)</td></tr><tr><td>4</td><td>Detectable weakness of hip flexion while supine (full flexion of knees)</td></tr><tr><td>5</td><td>No detectable weakness of hip flexion while supine</td></tr><tr><td>6</td><td>Able to perform partial knee bend</td></tr></table>
Ambulation may be considered when the Bromage Score is 6 and the labouring patient has the ability to lift legs one at a time.

If Bromage Score has been assessed at level 1 to 3, the care provider should notify the anaesthesiologist in accordance with institutional practice and/or policies. If the patient is receiving a continuous epidural infusion, stop infusion and notify the anaesthesiologist in accordance with institutional practice and /or policies.</td></tr>
<tr><td>Initials</td><td>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 1 of the Partogram.</td></tr>
</table>

Page 4: Progress Notes

- Document in chronological order any pertinent or otherwise unaccounted-for information, evaluations, variances, nursing actions, responses, or communication with members of the perinatal care team.
- Documentation should be completed at the time of an event or action, or as close to that time as reasonably possible.
- If additional space is required, please continue narrative notes on RCP form 07 (Maternal & Newborn Progress Notes)

Page 5: Second Stage of Labour

Information	Description
Full Dilatation: Date & Time	Document the date and time full dilatation was determined. You may choose at this time to notify the patient's physician or midwife if they are not present. Document in Progress Notes.
Active pushing started: Date & Time	Document the date and time the labouring patient commenced pushing; this is the beginning of the active second stage of labour. Document communication with the patient's physician or midwife in Progress Notes.

Page 5: Fetal Health Surveillance (SOGC 2020)

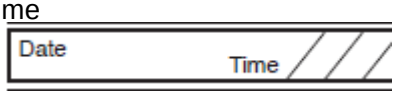
Table 23. Summary of recommended frequency of assessments and documentation

	IA FHS	EFM FHS	MHR[a]
Latent phase of labour if admitted to birthing area or individualized based on maternal fetal status if in triage or midwifery care at home (not admitted to hospital)	Q 1 hour	Q 1 hour	On admission and when determining baseline FHR
Active first and passive second stage	Q 15–30 minutes	Q 15 minutes	Q 4 hours with intact membranes OR Q 2 hours with ruptured membranes
Active second stage	Q 5 minutes	Q 15 minutes IF continuous tracing and caregiver continuously present[21]	Q 15–30 minutes[b]

[a] Additionally done any time there is uncertainty between the MHR and FHR and if intrauterine resuscitation is initiated.

[b] Consider a continuous tracing using tocodynamometer if available and document every 15 minutes.

EFM: electronic fetal monitoring; FHR: fetal heart rate; FHS: fetal health surveillance; IA: intermittent auscultation; MHR: maternal heart rate.

Information	Description
Date and time 	Record date and time of assessment. Time intervals should be continuous and will vary based on the move from passive to active second stage; this will also vary based on the mode of FHS assessment. Refer to SOGC's Table 23 above.
Fetal Health Surveillance, Contractions, Oxytocin dose, and Maternal Assessments	Document assessments in accordance with recommendations above. *Details of fetal health surveillance interpretation, maternal assessments and other documentation standards are on pages 11-17*. Continue to document relevant information relating to second stage in Progress Notes as described page 19.

Page 5: Second Stage: additional details

Information	Description
Regional Analgesia: Bolus/Rate	Document when a bolus of regional analgesic has been administered by the anaesthesiologist (or delegate), or the rate of continuous infusion, or in accordance with local policy or practice.
Bromage 4-6	Assess and document every hour: Yes or No **Score** / **Criteria** 1 – Complete block (unable to move feet or knees) 2 – Almost complete block (able to move feet only) 3 – Partial block (just able to move knees) 4 – Detectable weakness of hip flexion while supine (full flexion of knees) 5 – No detectable weakness of hip flexion while supine 6 – Able to perform partial knee bend If Bromage Score has been assessed at level 1 to 3, the care provider should notify the anaesthesiologist in accordance with institutional practice and/or policies. If the patient is receiving a continuous epidural infusion, stop infusion and notify the anaesthesiologist in accordance with institutional practice and /or policies.
Patient Position	Document the position of the labouring patient using free text. Consider position changes for comfort, to evenly distribute regional medications (if applicable) or to enhance labour progress.

Effectively Pushing (Y/N)	Assess patient's ability to effectively assist the fetus with descent; if efforts are ineffective over several contractions, consider alternative positioning. **If No, further assessment and information should be documented in the Progress Notes.*
Somnolence Score	For labouring patients who have received medications that may suppress respiratory efforts: 1 = awake and alert: no action needed 2 = sedated but arousable: no action needed 3 = heavily sedated and difficult to arouse, drifts off during conversation: requires action/decrease dose 4 = unresponsive or somnolent, minimal or no response to physical stimulation: unacceptable, stop opioid, consider administering Naloxone For more detailed information please refer to page 10 of RCP's clinical resource *Working with Pain in Labour*
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 1 of the Partogram.

Page 6: Vaginal Birth

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

Information	Description
Parturient's position for delivery	Indicate the delivering patient's position at the time of baby's birth: Supine Side-lying Semi-sitting Squatting Other (use free text to describe)
Delivery of male/female at _____ h by SVD (spontaneous vaginal delivery), Vacuum*, or Forceps*	Document the biological sex of the baby and time of birth and indicate whether the birth was spontaneous, or assisted with vacuum and/or forceps. For assisted vaginal birth additional documentation is recommended: Time of application(s): Traction start time(s): Complete details of an assisted vaginal birth should be documented in a separate note by the operator. The SOGC (2019) suggests the following format: • Date/Time • Physician • Indication • Record of discussion with the labouring patient of the risks, benefits, and options • Position and station of the fetal head, (vaginally and abdominally) • Amount of moulding and caput present • Assessment of maternal pelvis • Assessment of fetal heart rate and contractions • Type of vacuum or forceps used • Number of attempts and ease of application of vacuum or forceps • Duration of traction for forceps and duration of application for vacuum (start and stop time noted), and force used • Any rotation applied with forceps or autorotation that occurs with vacuum • For vacuum, number of pop-offs • Position of chignon on fetal scalp (vacuum): flexing versus deflexing; median versus paramedian • Description of any maternal and neonatal injuries • Initiation of monitoring for subgaleal hemorrhage (vacuum)

Page 6: Vaginal Birth (continued)

Information	Description
Placenta delivery time	Indicate time of placenta delivery
Uterotonic: Oxytocin	Indicate dose and route of oxytocin administration
Uterotonic: other options *Those caring for patients who have experienced cesarean delivery may also choose to make note in this space of additional uterotonics used.*	Indicate additional uterotonic medications given, including time, dose, and route. Additional details should be documented in accordance with the severity of postpartum blood loss, patient response, and additional measures taken as required. Indicate location of information in health record (e.g. Progress Notes, OR record, massive transfusion record, etc.)

Page 6: Initial Mother-Baby Contact (all births)

Information	Description
Skin-to-skin contact	Indicate time skin-to-skin contact was initiated and document the duration. Skin-to-skin is recommended for all stable babies, regardless of delivery or feeding method, within 5 minutes of birth for at least 60 minutes.
Breast offered to baby	Indicate whether baby was offered the breast. Relevant details of baby's response can be recorded in Progress Notes, or a locally used breastfeeding record.
Skin-to-skin contact with other than mother: Reason	Skin-to-skin contact may be initiated with other parent or support person; provide written description

Page 6: Fourth Stage: Postpartum Assessments

- **The frequency with which assessments are completed and documented should be guided by clinical judgment in consideration of the overall clinical situation and presence of intrapartum or postpartum risk factors for adverse outcomes (e.g. postpartum haemorrhage). The goal is to ensure physiological stability is maintained. Suggested frequency of assessments listed are for the first few hours following birth and do not include the ongoing assessments recommended during the postpartum stay.**
- Following vaginal birth, assessments of the stable postpartum patient should be completed every 15 minutes for at least the first hour in accordance with standards set by your institution.
- Following cesarean birth, assessment of the stable postpartum patient should be performed every15 minutes for the first hour, then hourly x 3 hours, and then in accordance with standards set by your institution.

Information	Description
Time	Document the time of the assessment and findings within the appropriate time column.

Blood Pressure, Pulse	• Suggested frequency for vaginal birth:
	  ○ Q 15 minutes for 1 hour
	  ○ Then at 2 hours
	• Suggested frequency for cesarean birth:
	  ○ Q 15 minutes for 1 hour
	  ○ Then hourly x 3 hours

Temperature	Assess within first hour following birth and document findings.

Respirations	• Suggested frequency post Epimorph (or refer to anaethesiologist's orders):
	  ○ Q 30 minutes for 2 hours
	  ○ Then Q 1 hour x 15 hours

Oxygen Saturation	• Suggested frequency post Epimorph (or refer to anaethesiologist's orders):
	  ○ Q 30 minutes for 2 hours
	  ○ Then Q 1 hour x 15 hours

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

Lochia (continued)	• Suggested frequency for vaginal birth:
	  ○ Q 15 minutes for 1 hour
	  ○ Then at 2 hours
	  ○ Then as required by nursing judgment and/or self-report
	• Suggested frequency for cesarean birth:
	  ○ Q 15 minutes for 1 hour
	  ○ Then at 2 hours
	  ○ Then Q 4 hours x 24 hours
	  ○ Then as required by nursing judgment and/or self-report

Information	**Description**
Perineum	Examine and document integrity of perineum (e.g. intact, degree of laceration, sutures in place, swelling, bruising, ice pack applied).

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.
	• Suggested frequency for vaginal birth:
	  ○ Q 15 minutes for 1 hour
	  ○ Then at 2 hours
	  ○ Then as required by nursing judgment and/or self-report

Dressing	Describe abdominal incision dressing
	• Suggested frequency for cesarean birth:
	  ○ Q 15 minutes for 1 hour
	  ○ Then at 2 hours
	  ○ Then Q 4 hours x 24 hours
	  ○ Then as required by nursing judgment and/or self-report

Bladder assessment	Assess relative to fundal checks. Document time and amount of urine output (mL), and whether the patient 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 1 of the Partogram.

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

Information	Description
Epidural Catheter removed intact by _____	Indicate whether epidural catheter was removed intact and by whom; document date and time
Transferred to Room #_____	Document the room number to which the patient and infant were transferred, including the date and time. Indicate whether they were transferred via wheelchair or stretcher, or if they ambulated.
Infant transferred to nursery	Indicate whether the infant was transferred to a nursery separate from the mother/postpartum patient, and document the reason.

References:

Association of Women's Health, Obstetric and Neonatal Nurses (2017). Perinatal Orientation and Education Program, Fourth Edition.

IWK Health Centre (2019) Patient Controlled Epidural Analgesia (PCEA) for Women in Labour Policy #7002.

Magee LA, Pels A, Helewa M, Rey E, von Dadelszen P, Canadian Hypertensive Disorders of Pregnancy Working Group (2014). Diagnosis, evaluation, and management of the hypertensive disorders of pregnancy. Pregnancy Hypertens. 2014;4:105-45.

Nova Scotia Health (2021) Fetal Health Surveillance: 'Fresh Eyes Approach' Policy # MC-LD-020

Nova Scotia Health (2021) Induction and Augmentation of Labour: Oxytocin Infusion Protocol DRAFT Policy # MC-LD-003.

Perinatal Services BC (2011). Obstetrics Guideline 20: Postpartum Nursing Care Pathway

Reproductive Care Program of Nova Scotia (2019). Clinical resource: *Working with pain in labour: Systemic medications*

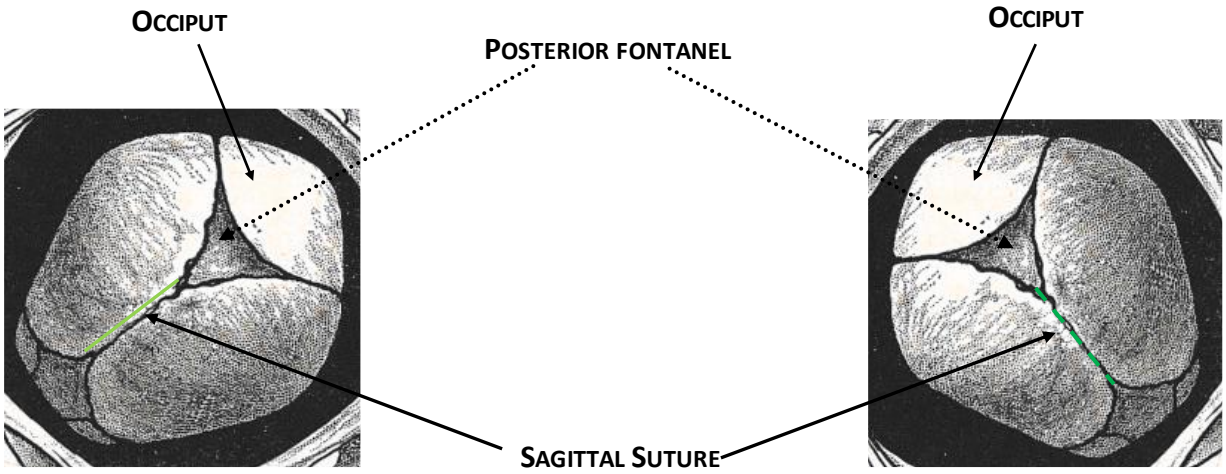
Society of Obstetricians and Gynaecologists of Canada (2019). Clinical Practice Guideline No. 381: Assisted Vaginal Birth. J Obstet Gynaecol Can 2019;41(6):870−882.

Society of Obstetricians and Gynaecologists of Canada (2020). Clinical Practice Guideline No. 396: Fetal Health Surveillance: Intrapartum Consensus Guideline. J Obstet Gynaecol Can 2020;42(3):316−348.

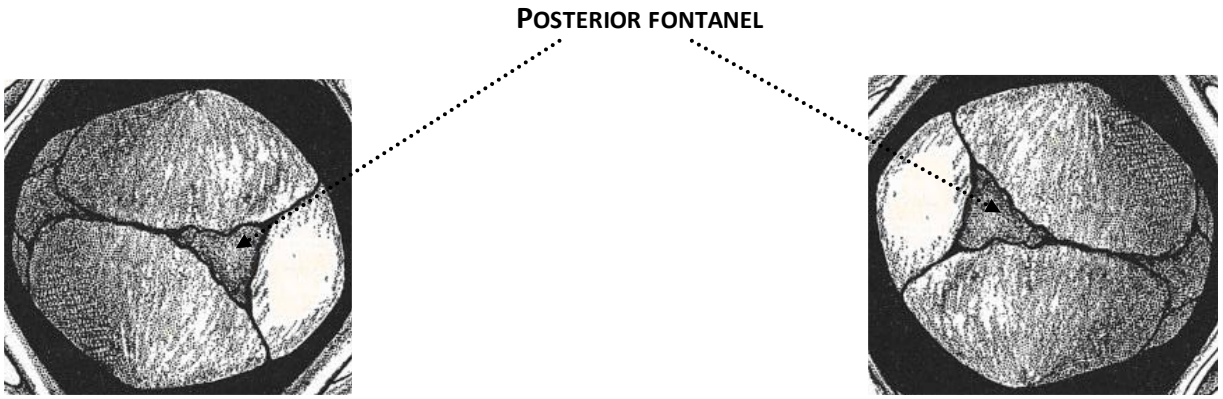
Society of Obstetricians and Gynaecologists of Canada (2016). Clinical Practice Guideline No. 336: Management of Spontaneous Labour at Term in Healthy Women. J Obstet Gynaecol Can 2016;38(9):843-865.

Assessing Fetal Position (cephalic presentation): suture lines and fontanels

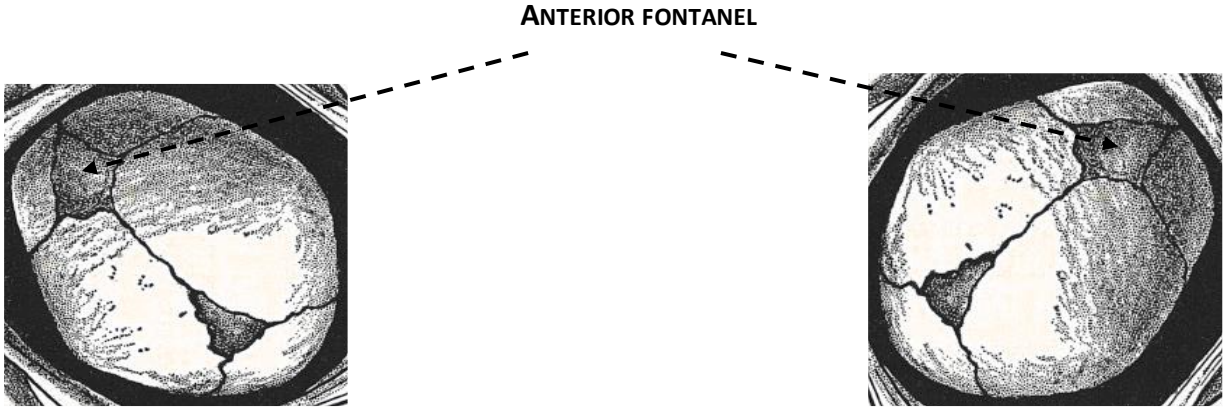
- The patient is positioned to prevent supine hypotension; but the position of the fetal skull is determined relative to the maternal pelvis with the pubis at 12 o'clock.
- Locate the sagittal suture and palpate along until you locate the posterior fontanel (where the sagittal suture meets the lambdoid sutures, which frame the occiput).



Left Occiput Anterior (LOA) Right Occiput Anterior (ROA)



Left Occiput transverse (LOT) Right Occiput Transverse (ROT)



Left Occiput Posterior (LOP) Right Occiput Posterior (ROP)

LML 2019: Images copied from Davis ME, Sheckler CE (1951). DeLee's Obstetrics for Nurses (15th Ed.)