



GUIDELINES FOR COMPLETION OF REGIONAL LABOUR RECORD

The regional **Labour Record** has been developed by the Southwestern Ontario Perinatal Partnership (SWOPP) and is based upon input received from all of the hospitals offering birth care in the region. The intent of this form is to promote a consistently high standard of intrapartum care throughout southwestern Ontario.

The Labour Record is to be initiated at the time of admission of patients who either are currently in active labour or who are to be induced into labour. Active labour is defined as regular uterine contractions with cervical dilatation of 3 to 4 cm. dilatation.¹

This record is **not intended** for patients scheduled for an elective Caesarean Section. Guidelines concerning the frequency of documentation will reflect current national guidelines endorsed by Health Canada and the Society of Obstetricians and Gynecologists of Canada (SOGC). In an effort to facilitate the constant attendance of a health care provider offering supportive care during active labour, it is recommended that the Labour Record be completed at the bedside.

The name of the patient should be documented in the space provided on the top of each panel. Some hospitals might also require the patient's admission number to be entered into this space. This is particularly important for hospitals that retain microfiche copies of their health records.

FLUID BALANCE:

Ensure that the date, time, site, gauge of each intravenous start and the initials of the person performing the venipuncture are included for every IV start at the bottom of the page. Each IV solution should be numbered individually at the top of the page and correspond with the same number used on the intake column.

When inserting a urinary catheter, ensure that the date, time, type and size of the catheter used are documented in the space provided at the bottom of the fluid balance record.

OBSTETRICAL ADMISSION ASSESSMENT:

This assessment is intended to provide easy access to updated clinical information upon admission in active labour or induction of labour.

SIGNATURE PROFILE:

All health care providers that document on the Labour Record should provide their full name (printed), status, signature and initials.

PARTOGRAM:

Date:

Ensure that the date reflects the date at which the Labour Record was initiated **and** the subsequent day if labour progresses beyond 2400 hrs.

Time:

When the Labour Record is initiated, the time on the hour should be entered in the first space followed by the hourly time respectively across the form (eg. 0500 hrs., 0600 hrs., 0700 hrs. etc.). In this way each hour is subdivided by the vertical lines into 15 minute segments, allowing for ease of documentation of the fetal heart rate. It also gives an accurate graphic display of the progress of labour.

Temperature:

Place the numerical value in the appropriate space. For the uncomplicated labour it is usually unnecessary to assess the temperature more than every 4 to 6 hours.² The temperature should be assessed more frequently if there are indications of infection or other extenuating circumstances. Follow clinical judgment/hospital policy.

Respirations:

Place the numerical value in the appropriate space. It is usually unnecessary to assess respirations more than every 4 to 6 hours in the uncomplicated labour.² Respirations however, should be assessed more frequently when respiratory function is compromised or when administering narcotics or other medications such as Magnesium Sulphate etc. Assess respirations as per clinical judgment/ hospital policy.

Blood Pressure:

Space is provided for the documentation of blood pressure every 15 min. This is not usually required unless there are other extenuating circumstances that can alter BP such as Gestational Hypertension, administration of some medications etc.² Follow clinical judgment/ hospital policy.

Maternal Pulse:

It is usually unnecessary to assess the pulse more than every 4 to 6 hours unless risk factors are identified.² Document according to key as per clinical judgment/ hospital policy.

Fetal Heart Rate (FHR):

When using intermittent auscultation (IA), assess the FHR immediately after a contraction for a full minute. When using either IA or electronic fetal monitoring (EFM), the FHR should be assessed every 15 minutes after a contraction during the active phase of labour and at least every 5 minutes during the second stage of labour once the woman has begun pushing.³ Document according to the key provided.

The baseline FHR may be documented as one numerical value using a dot on the graph provided. This assists with the visual detection of fetal heart rate trends. Alternatively, the baseline FHR may be documented as a range (eg. 130 – 140 bpm) in the box entitled “baseline”. (see below)

Fetal Assessment:

Mode: Enter the appropriate abbreviation according to the key provided.

Baseline: In addition to or instead of documenting the FHR on the graph provided, it may be documented as a range (eg. 130 – 140 bpm). The baseline is the approximate mean FHR rounded to increments of 5 bpm during a 10 minute segment of the tracing. In any 10 minute window, the minimum baseline duration must be at least 2 minutes. The baseline should exclude accelerations or decelerations of the FHR. It should also exclude FHR observed during contractions or in the presence of obvious fetal movements as these events can alter the FHR. .⁴

Rhythm: Enter the appropriate abbreviation according to the key provided.

Variability: “Variability has been defined as FHR fluctuations in the baseline FHR over 1 minute.”⁵ Documentation of variability is only appropriate when using continuous electronic fetal monitoring. Use the key provided.

Accelerations: “Accelerations are abrupt increases in the FHR 15 beats per minute above the baseline, lasting at least 15 seconds but less than 2 minutes. Accelerations of ≥ 10 min. are a baseline change.”⁶ Document according to key provided.

Decelerations:

**See SOGC Practice Guideline- Fetal Health Surveillance in Labour for definitions of each type of FHR deceleration.

When using IA, decelerations should be documented as either absent (A) or present (P). When using continuous EFM use the key provided to indicate the type of deceleration. Late, variable or prolonged decelerations should be further documented in the narrative note, which should discuss additional clinical observations, assessments, interventions and outcomes according to hospital guidelines.

Uterine Activity:

Mode: Enter the appropriate abbreviation according to the key provided.

Frequency: Document frequency of contractions in minutes (eg. Q 5 min.)

Duration: Document duration of contractions in seconds.

Intensity: Document using the key provided. If an intrauterine pressure catheter is in situ document in mm. Hg.

Relaxation: The uterus should be indentable between contractions to allow for adequate re-oxygenation of the utero-placental-fetal unit. The uterus should be soft between contractions for at least 30 seconds. If using an intrauterine pressure catheter, normal resting tone is considered to be < 15 mm Hg.⁷

Progress of Labour:

Document dilatation of the cervix using an “x” at the time of the vaginal examination on the graph provided. Use the scale from 1 to 10 cm. on either side of the graph. At the same time document the name of the person who performed the examination vertically beside the “x” placed on the graph. To demonstrate the progress of cervical dilatation, the “x”s for each subsequent vaginal examination can be joined.

Similarly if possible, document the station of the presenting part using a “•” and join the “•”s to demonstrate the progress of fetal descent. Use the scale from –5 to +5 cm. on either side of the graph

The time of artificial rupture of the membranes (ARM) or spontaneous rupture of the membranes (SRM) should be indicated in the space provided on the left side of the graph.

Membranes/Amniotic Fluid:

Document the status of the membranes and the colour of the amniotic fluid according to the key provided. Documentation of the colour of the amniotic fluid should be made at the time of membrane rupture and subsequently thereafter if any change is noted.

Oxytocin Infusion:

The volume and cumulative total of the IV oxytocin solution is documented on the Fluid Balance record. Document the exact time and dosage (mu/min). **In addition to the dosage, the next blank space may be used for documentation of the infusion rate (eg. drops/min. or mls./hr.) according to hospital policy.** The initials of the person starting the oxytocin infusion or changing the dosage should be entered each time.

Effectiveness of Pain Management:

By obtaining feedback from the patient use the key provided to indicate the effectiveness of pain management. For patients that are not coping with the pain of labour, use hospital guidelines re: further documentation in the narrative note.

Labour Support:

Use the remaining spaces to indicate the type of labour support provided. Labour support consists of:

- a) Comfort Measures – physical support such as massage, Jacuzzi etc.
- b) Information/Teaching – instructions, explanations
- c) Advocacy – relaying the woman or couple’s wishes to other team members, acting on the woman’s behalf.
- d) Emotional Support – encouragement, reassurance.⁸

Additional Space:

If not being used to document labour support, some care providers may wish to use the additional spaces at the bottom for documenting additional parameters according to the individual needs of the patient eg. MgSO₄ infusion, reflexes etc. If not required, the additional spaces can simply be stroked out.

Initials:

The initials of the primary care nurse/midwife should be entered in the space provide. The initials should also be reflected on the signature profile.

NURSING ASSESSMENT/SIGNIFICANT FINDINGS

When observations noted on the Labour Record fall outside of normal limits, further documentation should be completed under “NURSING ASSESSMENT/SIGNIFICANT FINDINGS”. All nursing assessments should be numbered and listed in the column at the top of the flow sheet. The following are examples of assessments that might be included for further documentation of significant findings:

- Fetal Well being Assessment
- Uterine Activity Assessment
- Pain Assessment
- Neurological Assessment
- Cardiovascular Assessment
- Respiratory Assessment
- Gastrointestinal Assessment
- Genitourinary Assessment
- Integumentary Assessment
- Musculoskeletal Assessment
- Neurovascular Assessment

Additional assessments may be listed and the corresponding significant findings documented as required. Using the corresponding number, indicate under “Significant Findings” the assessment to be documented on and complete details re: subjective, objective data and interventions in the space provided. If additional space is required for ongoing documentation, use the hospital progress notes and include it with the Labour Record.

It is recommended that the hospital’s interdisciplinary progress notes be used to document the following:

1. Communication between caregivers
2. All major psychological/family concerns. **These are not to be documented on the bedside Nursing Assessment/Significant Findings flow sheet**
3. Incident Reports

IMMEDIATE POSTPARTUM:

The immediate postpartum period (fourth stage of labour) is a time of significant psychological and physical adjustments for the new mother/family. A thorough ongoing physical assessment of the mother during this time should be individualized according to her history and birth experience. Frequent assessments of the mother’s vital signs, uterine fundus (both height and consistency), lochia and perineum should be made according to the key in the flow sheet provided. As an example, a uterine fundal height that is one fingerbreadth above the umbilicus is documented as 1/U. Whereas a fundal height that is one fingerbreadth below the umbilicus is recorded as U/1. A reasonable frequency of assessment might be every 15 minutes for the first 1 to 2 hours. However, assessments and documentation should be made according to the clinical judgment of the care provider and the policy of the hospital.

Assessments usually made less frequently such as assessments of the abdominal wound for C/S patients, pain, voiding, hemorrhoids, breastfeeding should be documented in the space provided.

Further comments concerning significant findings, interventions and evaluation of the actions taken should be documented under “Additional Comments”.

Concerns regarding psychological/family adjustments should be documented on the hospital interdisciplinary progress note. **These should not be recorded on the bedside Immediate Postpartum flow sheet.**

REFERENCES:

1. Schurmanns N et al. Society of Obstetricians and Gynecologists of Canada (SOGC) Clinical Practice Guidelines: Policy Statement No 71: Healthy Beginnings: Guidelines for Care During Pregnancy and Childbirth. SOGC Journal Ottawa: December 1998. 43.
2. Dept. of National Health and Welfare. Family – Centred Maternity and Newborn Care - National Guidelines. Ottawa. 1987, 52.
3. Liston R et al. Society of Obstetricians and Gynecologists of Canada (SOGC) Clinical Practice Guideline Policy Statement No. 112: Fetal Health Surveillance in Labour. Ottawa. March 2002. 3.
4. The Canadian Perinatal Regionalization Coalition (CPRC). Fetal Health Surveillance in Labour. 3rd ed., Vancouver, September 2002, 79.
5. SOGC Clinical Practice Guideline No. 112, p.7.
6. SOGC Clinical Practice Guideline No. 112, p. 8.
7. CPRC, p. 47.
8. Family Birth Centre, St. Joseph’s Health Care, London. Documentation for Record of Labour. August 2002

Disclaimer: The Maternal Newborn Child and Youth Network has used practical experience and relevant legislation/national guidelines to develop this documentation record. We accept no responsibility for interpretation of the information or results of decisions made based on the information documented on this record.