Perinatal Forms Guideline 4
A Guide for Completion of the
BRITISH COLUMBIA
LABOUR PARTOGRAM (BCPHP 1583)

February, 2010

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Provincial Health Services Authority
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While every attempt has been made to ensure that the information contained herein is clinically accurate and current, the BC Perinatal Health Program acknowledges that many issues remain controversial, and therefore may be subject to practice interpretation.

Introduction

The British Columbia Labour Partogram (BCPHP 1583) is a revised form developed to facilitate 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 a comprehensive database for the British Columbia Perinatal Database Registry (BCPDR), which includes data collection from the entire suite of Provincial Perinatal Forms. The mandate of the BCPHP includes the ongoing collection, analysis, interpretation and dissemination of perinatal data to monitor provincial perinatal outcomes and to improve health care initiatives.

Throughout this guide, we make reference to the Decision Support Tools in the Guidelines for Registered Nurses - Core Competencies: Management of Labour in an Institutional Setting if the Primary Maternal Care Provider is Absent (2009) as a basis for evidence-informed care.

Guiding Principles

The BC Labour Partogram is designed for use in conjunction with the BC Perinatal Triage and Assessment (PTA) Record (BCPHP 1590) and the Maternal Postpartum and Newborn Care Paths.

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 end of 3rd 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 standardized 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/fetal conditions
- Seamless integration of maternal postpartum and newborn care paths as much as possible
- Support use by multidisciplinary care providers
- Facilitate data collection for BC Perinatal Database
- Enable electronic archiving or formatting

General Guidelines

- The BC Perinatal Triage and Assessment (PTA) Record 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 (DST No. 4: Evaluation of Progress of Labour/Dystocia). The cervix is expected to progress at approximately at 1 cm per hour in established labour.
  - For an oxytocin induction
- Assess relevant history and pregnancy information by:
  - Interviewing the woman
  - Reviewing the:
    - Antenatal Record Part 1 and 2
    - BC PTA Record
    - Other relevant medical documentation
- Perform a maternal physical and psychosocial assessment
- For any identified variances:
  - Document in the Variance Record/Progress Notes
  - Communicate with the primary care provider (PCP) or designate:
    - Exact times 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
- ***For Variance(s) – Using an asterisk * in any space when further details about assessment, interventions or communication have been documented in the Variance Record/Progress Notes.***

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

- Under the "item" column, fields collected in the database are identified with an asterisk (*)
- The term "document" instructs to write out the requested information in the space provided
- The term "indicate" instructs to check (√) the box provided

1.0 Demographics and Background Information

- Short summary of the woman's key admission history, labour information and birth plan
- Complement information on the BC PTA Record

Item	Description
Addressograph/Label area	Demographic information includes: patient surname, given name, address, phone number, personal health number, physician/midwife name, date.
Partogram No.	When more than one Labour Partogram is required, number successive partogram e.g. 1, 2…
Gravida*	Document the total number of prior and present pregnancies regardless of gestational age, type, time, outcome or method of termination. Twins or multiples are counted as one pregnancy. A blighted ovum and hydatidiform mole are classified as a gravida.
Term*	Document the total number of previous pregnancies with birth occurring at greater than 37+0 weeks gestation (includes 37^0 – 37^6).
Preterm*	Document the total number of previous pregnancies with birth occurring between 20 – 36+6 weeks gestation (includes 36^0 – 36^6).
Abortion*	Document the total number of previous terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 grams.
Living*	Document the total number of children, who are presently living, the woman has given birth to. Does **not** include current pregnancy.
Admission	Document the admission date and time.
EDD (Expected Date of Delivery)	Document the expected date of delivery by using the last normal menstrual period date (if known) and/or confirmed by the initial ultrasound EDD by US done at <20 weeks gestational age.
Regular contr*	Document the date and time of onset of regular contractions.
Gestational age ____ wks	Document the number of weeks gestation from LMP, if known or as determined by US done at <20 weeks gestational age.
SROM (Spontaneous rupture of membranes) ARM (Artificial rupture of membranes)*	Indicate either SROM or ARM. Document the date and time.
Membranes intact	Indicate if the membranes are intact - at the time of completing this section.
Mec (Meconium) noted	If meconium was noted, document the date and time noted.
Amniotic fluid colour	Document the colour of the amniotic fluid (when the SROM or ARM took place) as: • Clear • Meconium stained • Bloody

1.0 Demographics and Background Information *cont.*

Item	Description
Last ate	Document the date and time the woman last ate a full meal.
Last drank	Document the date and time the woman last drank fluids.
Current weight ____ kg/lb*	Document the woman's current weight in kilograms (preferably).
ABO (Blood) group Rh*	Document the woman's ABO and Rh blood typing.
GBS (Group B Streptococcus) results*	Indicate the woman's GBS screening status as positive, negative, unknown. Information can be obtained from Antenatal Record Part 2.
Allergies	Indicate if the woman has allergies, specify and document adverse reactions.
Medications	Indicate if the woman is taking any medications; list the medications.
Risk factors/concerns	Indicate if the woman has risk factors or concerns. List any risk factors that may influence the management or outcome of this labour and birth.
Birth plan	Review and document the woman's birth plan.
Support person(s)	Record name(s) of support person(s).

2.0 Vaginal Exam

- Aid in visualization of labour progress with cervical assessment and the number of hours since admission

Item	Description
Date/time	Record date and time. Time columns are divided into hourly intervals.
Hour	Denote the number of hours since the woman's admission. The Labour Partogram provides for 12 hours of documentation. The graph is drawn to a scale of 1:1 i.e. on the left side, each square represents 1 cm of dilatation; along the top, each square represents 1 hour (WHO, 1994).
Cervical dilatation*	Using a "•" indicate the dilatation of the cervix (from 0 – 10 cms) from vaginal examination (VE). Graph cervical dilatation finding in the column representing the appropriate hour. For example: • Admission VE at 0800 found woman 3 cm dilated • Next VE at 1200, 7 cm dilated - findings will be graphed 4 columns to the right of the 0800 exam The use of Alert and Action Lines is encouraged to assess/ intervene on delayed progress of labour.

Item	Description
Cervical dilatation* *(cont.)*	***Alert and Action Lines*** • Once the woman reaches 3 cm dilatation, draw a diagonal line called the **Alert Line** from 3 cm to 10 cm. This line represents the rate of expected labour progress at 1 cm per hour. • Also draw another diagonal line called the **Action Line**, starting from four columns to the right (joining 3 cm to 10 cm). The Action Line is drawn 4 hours past the Alert Line as a trigger that labour is now 4 hours behind what is normally expected, and interventions to augment labour should be considered. **NOTE:** The use of Alert and Action Lines should be clearly stated in the hospital policy on labour assessment. The hospital policy should also indicate whether a 2 or 4 hour Action Line is adopted, and include nursing responsibilities when labour progress is delayed.
Station*	• Using an "**X**" (-3 to +3) indicate the descent of the presenting part, graph the finding in the same column as the cervical dilatation
Cervical length*	Document the length of the cervix in cms.
Cervix position/consistency*	Document the position of the cervix as: • A = Anterior • M = Mid • P = Posterior Document the consistency of the cervix as: • S = Soft • Med = Medium • F = Firm
Presenting part position*	Document position of the presenting part as: • L = Left • R = Right • O = Occiput • S = Sacral • A = Anterior • T = Transverse (lateral) • P = Posterior
Moulding/caput	Document M = Moulding or C = Caput if this is felt during the VE.

2.0 Vaginal Exam *cont.*

Item	Description

Amniotic fluid	Document if there is visible amniotic fluid as:
	• Amount
	  ▪ Ø = Absent
	  ▪ Sc = Scant
	  ▪ Mod = Moderate
	  ▪ L = Large
	• Colour
	  ▪ CL = Clear
	  ▪ BL = Bloody
	  ▪ Mec = Meconium

Blood/show	Document if blood or show is present, record as: • Sc = Scant • Mod = Moderate • L = Large
Examiner	Record the name of the person performing the VE.

3.0 Fetal Assessment

Refer to Decision Support Tool No. 2: Intrapartum Fetal Health Surveillance

- Recommended frequency of auscultation (SOGC, 2007):
  - Immediately after a contraction for a full minute.
  - First stage: latent phase – approximately q 1 h if more than 4 contractions/hour, otherwise as clinically indicated (ideally the woman is at home). Check to see if she is in labour.
  - First stage: active phase – q 15 – 30 min.

Item	Description
Date Time Hour	• Record date and time of assessments/interventions. • **For time:** the two-page flow sheet (p.2 and 3) provide enough space for 12 hours of documentation. The 12 hours are divided into 15 minutes intervals; the heavier lines represent hourly division. Thus, the columns indicate :00, :15, :30, :45 minutes. Begin the first box at the hour the woman is admitted. For instance if the admission time is at 0915, label the second column as 0915, and begin documentation. • **For Hour:** Indicate the number of hours since admission.

Item	Description
FHR*	The normal baseline FHR is between 110 - 160 bpm. If the FHR is outside the normal range (a variance) the darker dotted lines trigger an alert to perform further assessments that include primary care provider (PCP) notification. • For intermittent auscultation (AUSC), use a "•" to document the baseline FHR. • For external EFM, use a "X" to document baseline FHR. • For FECG, use a "O" to document baseline FHR.
Rhythm [R,I]/Variability	If using IA (Intermittent Auscultation), document the rhythm of the FH as: • R = Regular • I = Irregular If using EFM, document the variability of the FH: • ø = Absent (undetectable) • ↓ = Minimal (≤ 5 bpm) • + = Moderate (6 – 25 bpm) • ↑ = Marked (> 25 bpm)
Accelerations	Document accelerations as: • √ = Present/Spontaneous • ø = Absent/Not heard • SS = Present/Scalp stimulation
Decelerations	Document decelerations as: • √ = Present • ø = Absent/Not heard If using EFM, document type of decelerations: • E = Early • V = Variable* • L = Late* • P = Prolonged* Describe decelerations in terms of ↓ __ bpm x ___ sec/min in Variance Record/Progress Notes.
Classification	Classify the EFM FHR tracing as: • N (Normal) • ATYP (Atypical) • ABN (Abnormal) Describe specific interventions for atypical or abnormal findings in the Variance Record/Progress Notes.

4.0 Contractions

Item	Description

Frequency* [in 10 min]/Intensity	Document the:
	• Frequency of contractions - the time from the beginning of one contraction to the beginning of the next). For the purpose of the Labour Partogram document the number of contractions in 10 minutes. (For example: 4 per 10 minutes)
	• Intensity of the contractions - strength of contraction assessed by palpation and asking the woman what type of pain she is feeling:
	  ▪ M = Mild
	  ▪ Mod = Moderate
	  ▪ S = Strong
	  ▪ __mmHg (if an Intrauterine Pressure Catheter is used)

Duration* [in sec]	Document the duration of contractions – length of time in seconds the contraction lasts, from the beginning to the end. (i.e. 45 – 60 sec).
Resting tone	Document the resting tone of the uterus between contractions: • S = Soft • F = Firm • __ mmHg (IUPC)
IV Oxytocin ___ I.U./ ___ ml.	Document the oxytocin dosage of the prepared IV solution. Indicate if the oxytocin use is for the purpose of augmentation or induction of labour. Document the time and dose in Mu/min in the appropriate columns.

5.0 Meds Procedures Treatments

Item	Description

Meds (dose/route/time)
Procedures
Medications
	Document any medications, procedures or treatments. For example:
	• Medications – write the name of the medication, dose, route and frequency – if the same dosage is given indicate by initials in the appropriate time column
	• Procedures or treatments may include (but are not limited to):
	  ▪ Administration of Oxygen
	  ▪ Insertion of IUPC
	  ▪ Fetal scalp blood sampling

6.0 Maternal Assessment

Refer to:

- Decision Support Tool No. 4: Evaluation of Progress of Labour/Dystocia
- Decision Support Tool No. 5: Discomfort and Pain in Labour
- Decision Support Tool No. 5A: Administration of Nitrous Oxide

Item	Description
Blood pressure*	On the appropriate line, use the symbol "**v**" to indicate the woman's systolic blood pressure and the symbol "**^**" to indicate the woman's diastolic blood pressure. Blood pressures between 140 systolic and 90 diastolic are highlighted with dotted lines, more severe BP at **160** systolic and **110** diastolic are highlighted in **bold** text. This triggers an alert that includes further assessments and notification of the PCP for BP variances outside of the normal range.
Pulse	Use the symbol "•", to indicate the woman's pulse.
Temp	Document temperature with the symbol "**X**". Note the numbers **35** and **39** are highlighted in **bold** text. This triggers an alert that include further assessments and PCP notification for temperature variances outside of the normal range.
RR/O_2 Sat	Document as relevant, the respiratory rate (counted for one minute) and oxygen saturation as measured by the O_2 saturation monitor.
Non-pharmacologic	Document the non-pharmacologic measures used to support the labouring woman. This is a ***free text area***, examples may include: • Aromatherapy • Cool compresses • Warm compresses • Counter pressure • Fluids • Ice pack • Massage • Music • Reflexology • Shower • Tub/whirlpool • TENS • Pericare
Activity/Position	• Sit = Sitting • Std = Standing • RL = Right lateral • LL = Left lateral • SU = Supine • LI = Lithotomy • SF = Semi-Fowler's

6.0 Maternal Assessment *cont.*

Item	Description
Activity/Position *(cont.)*	• AMB = Ambulating • BB = Birthing ball • HK = Hands & knees • KC = Knee-chest • Sq = Squatting • TR = Trendelenberg
Urine*/Blood sugar [mmol/L]	Document the results of the • Urine test as: ▪ Protein • Neg (Negative), Trace, 1+, 2+, 3+ ▪ K (Ketones) • Neg (Negative), Trace, 1+, 2+, 3+ **Note:** Check Protein and Ketone test strips for specific values equivalent to 1+, 2+, 3+ ▪ V = Voided ▪ I&O = In and out catheter ▪ FC = Foley catheter inserted • Blood sugar from the glucometer testing in mmol/L (if performed).

7.0 Regional Analgesia

Refer to Decision Support Tool No. 5: Discomfort and Pain in Labour

Item	Description
Epidural, Spinal, Combined, PCEA*	Indicate the type of regional analgesic used: • Epidural • Spinal • Combined • PCEA (Patient controlled epidural analgesia)
1st Bolus at	Document the time the regional analgesic initial bolus was administered.
Continuous infusion at	Document the time the regional analgesic continuous infusion commenced.
Shift/total infused ___ mL	Document the amount of regional anesthetic infused at the end of a shift or when the infusion is discontinued.
Dr___called at___h Arrived at___h	Document the time the physician (anesthesiologist) was called and the time s/he arrived.
Bolus rate	Document the regional analgesic bolus rate.

<table>
<tr><th>Item</th><th>Description</th></tr>
<tr><td>R/L sensory</td><td>Document the right and left sensory levels testing with ice for numbness and indicate where 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 (Optimal)</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 and knees
• 1 = Partial (acceptable) – Just able to move knees and feet, unable to raise extended legs
• 2 = Almost complete – Notify Anaesthesiologist. Able to move feet only – unable to bend knees
• 3 = Complete – Notify Anaesthesiologist. Unable to move feet, knees or hips</td></tr>
<tr><td>Pain/Sedation Scale</td><td>Document the:
• Pain Scale from 0-10
▪ 0 = No pain
▪ 10 = Worst pain possible

• Sedation Scale as:
▪ 1 = Fully awake and oriented
▪ 2 = Drowsy
▪ 3 = Eyes closed but rousable to command
▪ 4 = Eyes closed but rousable to mild physical stimulation (earlobe tug).
▪ 5 = Eyes closed but unrousable to mild physical stimulation.

Adapted from Wilson Sedation Scale Score (Nemethy et. al. 2002).</td></tr>
<tr><td>Initials</td><td>Provide legible initials.</td></tr>
</table>

8.0 Variance Record/Progress Notes

Item	Description
Date/Time	Record date and exact time.
Focus	Indicate the reason or focus of documentation.
Progress Notes	Document in a chronological order any pertinent information, variances, nursing actions, responses or evaluation obtained during the maternal/fetal assessment.

9.0 IV (Intravenous) Starts

Item	Description
IV starts	Indicate the time, needle size, and site of IV initiation. Provide legible initials.

10.0 Intake and Output

- Indicate if a separate institutional Intake and Output Record is used
- If appropriate, tally totals and balance (positive or negative balance) of intake and output in the lines provided; totals may be calculated for a shift, a 12-hour period, or when a second Labour Partogram is necessary. Transfer cumulative balance to the next partogram
- If the woman is transferred to the OR, perform a cumulative total before leaving for the OR, then chart on a separate I&O record from then on
- Postpartum IV therapy – document on separate postpartum I&O record
- Do not record I&O on a Labour Partogram if the woman is not in labour
- For high risk patient with specific orders for fluid administration – use separate intake and output sheet

Item	Description
INTAKE Time Started, IV Solution, Vol Start, Vol Abs	Document: • Time the IV or oral fluids were initiated • Time and type of IV solution used • Time and volume of IV solutions started • Time and volume of IV absorbed
Vol Left	Document the time and amount of IV solution left at: • The end of the shift • End of 3rd stage • Transfer
Time Stopped	Document the time the IV solution was stopped. • Amount in bag absorbed
Oral	Document time and the amount (in mls) of oral fluids ingested.

10.0 Intake and Output *cont.*

Item	Description
INTAKE *(cont.)* TOTAL IV ABSORBED	At the end of the shift, when the IV is removed and at the end of the 3rd stage of labour or if woman is transferred from care document the total amount of IV absorbed.
TOTAL ORAL	At the end of the shift, at the end of the 3rd stage of labour or if woman is transferred from care document the total amount of oral intake.
12 HOUR INTAKE	Document the total 12 hour intake.
OUTPUT Time, Urine, Emesis, Blood	Document the time and amount (in ml) of: • Urine output • Emesis • Passage of blood
TOTALS	Document the total output: • At the end of the shift • End of 3rd stage • Transfer
12 HR OUTPUT	Document the total 12 hour output.
Previous cumulative balance (+/-)	Carry over and record previous intake and output balance e.g. from a previous labour partogram. Fluid balance = Total intake minus Total output; value may be negative or positive.
12 hour balance	Total current fluid balance from the partogram.
Total cumulative balance	Previous cumulative balance minus 12 hour balance.

11.0 Variance Record/Progress Notes

See Section 8.

12.0 Second Stage

Refer to:

- Decision Support Tool No. 2: Intrapartum Fetal Health Surveillance
- Decision Support Tool No. 4: Evaluation of Progress of Labour/Dystocia
- Decision Support Tool No. 6: Birth in the Absence of a Primary Care Provider
- Decision Support Tool No. 8A: Obstetrical Emergencies – Cord Prolapse
- Decision Support Tool No. 8B: Obstetrical Emergencies – Shoulder Dystocia

Item	Description
Full dilatation at*	Document the date and time the woman became fully dilated.
Active pushing started at	Document the date and time the woman commenced active pushing.
If applicable IUPC removed Foley removed	Indicate if applicable and document the time when the: • IUPC was removed • Foley catheter was removed
MD/RM notified/arrived at	Document the time the MD/RM was notified and arrived.
FHR mode*	Indicate the method of FHS: • AUSC • EXT EFM • FECG
Time/FHR/Notes, Initials	Document the exact time and FHR: • Immediately after a contraction for a full minute • Passive second stage – q 15 min before the onset of pushing • Active second stage – q 5 minutes (after a contraction) once the woman has begun pushing Document narrative notes during second stage, and any pertinent information as required. Provide legible initials.
Date/Time of birth*	Document the exact date and time of the birth. When the baby has completely emerged, birth is complete, and the second stage of labour ends
Oxytocin	Indicate if Oxytocin was given, document: • Time • Dose • Route (IM, IV) • By whom

13.0 Assisted Vaginal Birth Summary

Item	Description
Assisted Vaginal Birth Summary	Indicate if an assisted vaginal birth was required.
Analgesia/Anesthesia*	Appropriate analgesia/anesthesia should be used for an assisted vaginal birth, document: • Type • Dose • Route • Who administered the drug
Bladder emptied____ml at_____	For an assisted vaginal birth, ensure bladder is emptied, and document: • Amount of urine in ml • Time
Forceps*	Indicate if forceps assisted birth was performed and document the: • Type of forceps • Time forceps was applied • Time forceps was removed • If forceps delivery failed
Vacuum*	For vacuum assisted birth indicate: • Type of vacuum • Time vacuum was applied • Time vacuum was removed • Number of pop-offs (recommended maximum pop-offs is ≤ 3) • If vacuum delivery failed **When to Halt** • 3 pulls, over 3 contractions, no progress • 3 pop offs, without obvious cause • 20 minutes elapsed time and delivery is still not imminent (ALARM Course, 2009)
Performed by	Document the name of the person performing the assisted vaginal birth.
Assisted by	Document the name of the person assisting with the assisted vaginal birth.
Comments	Document any pertinent comments pertaining to the assisted vaginal birth.
Completed by	Provide signature of person completing this section.

14.0 Third Stage

Refer to:

- Decision Support Tool No. 7: Postpartum Hemorrhage

Item	Description
Time of placenta delivery*	Document the exact time the placenta delivered, marking the end of the 3rd stage of labour.
Cord gases collected*	Indicate if venous and/or arterial cord blood sample were collected.
Skin-to-skin contact at ____h	Documents the time maternal/newborn skin-to-skin was initiated.
To breast*	Indicate if the newborn went to the breast and if not, provide a reason.
If Third Stage 3rd prolonged Maternal Vital Signs (VS)	Document the maternal vital signs including BP, P, R. Indicate in the "See progress notes" box if further VS or documentation is required. Use the space provided at the end Section 14 or use a separate Variance Record/Progress Notes. **Note:** Document fourth stage maternal assessment on the Postpartum Care Path.
Manual removal of placenta*	Indicate if there was a manual removal of placenta and if so, indicate if the procedure took place in the LDR and document the type of analgesia given. If the procedure took place in the OR, document time to OR.
Completed by	Provide signature of person completing this section.

References

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World Health Organization (1994). Preventing prolonged labour: A practical guide. Part II: User's Manual.Geneva, WHO.

Obtaining copies of the BC Labour Partogram

- Individual practitioners may obtain copies of the forms from the local hospital.
- Facilities will order forms through Benwell Atkins. Refer to BCPHP website link http://www.bcphp.ca/Forms.htm for the order form.
- Contact the BC Perinatal Health Program (BCPHP) at 604.875.3737 regarding any feedback or questions about the perinatal forms.

Revision Committee

Members of the Labour Partogram/Perinatal Triage and Assessment Record Revision Committee:

The BC Perinatal Health Program (BCPHP) would like to acknowledge the committee who revised the BC Labour Partogram and developed the completion guide. Committee members included:

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