# Perinatal Forms Guideline 7
# A Guide for Completion of the BRITISH COLUMBIA PERINATAL TRIAGE & ASSESSMENT RECORD (BCPHP 1590)

February, 2010

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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 BC Perinatal Triage and Assessment (PTA) Record (BCPHP 1590) is a ***new*** form that replaces the Maternal Assessment Record (98/05); its purpose is to facilitate the assessment and triage of pregnant women in the perinatal period, in a structured, logical and standardized manner. It is first and foremost a form to facilitate consistent and complete documentation, communication, and continuity of care among health care providers and provides a guide for evidence-based care. Secondly, specific fields in the PTA 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 (BCPHP, 2009) as a basis for evidence-informed care.

## Guiding Principles

The BC Perinatal Triage and Assessment Record is designed for use in conjunction with the Labour Partogram 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
- Incorporate relevant information for antepartum assessment and labour admission through birth
- 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
- Facilitate early recognition, timely communication and intervention for changes in maternal/fetal conditions
- Seamless integration of other provincial records such as the Labour Partogram, maternal postpartum and newborn pathways 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 admission history and complements documentation on the Labour Partogram
- To obtain pertinent information on the PTA:
  - Confirm assessment data with the woman
  - Review Antenatal Record Part 1 and 2 and other relevant medical documentation
  - Perform a maternal physical and psychosocial assessment
- For any identified variances:
  - Document in the Interprofessional 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

**The following sections provide descriptive information on the items on the PTA:**

- 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

| Item | Description |
|---|---|
| Addressograph/label Area | Demographic information includes: patient surname, given name, address, phone number, personal health number, physician/midwife name and date. |
| Date/Time | Document the date and time of woman's arrival in Triage/Labour Birthing Unit. |
| Arrived by ambulance | Indicate if the woman arrived by ambulance or not. |
| Language preferred | Language most readily understood by the woman. Important when English is the second language. |
| REASON FOR VISIT* | Document the reason for the visit. For example:<br>• Query (?) Labour<br>• PTL (Preterm Labour) (Refer to DST No. 3: Preterm Labour)<br>• SROM (Spontaneous Rupture of Membranes)<br>• PPROM (Preterm Prelabour Rupture of Membranes)<br>• ↓ FM (Decreased Fetal Movement)<br>• ↑ BP (Increased Blood Pressure)<br>• Bleeding<br>• Version i.e. External Cephalic Version<br>• Induction<br>• For Medication(s)<br>• Postpartum complications<br>• Other reason(s) |
| Accompanied by | Document who accompanied the woman to the unit: partner/ friend, or specify in space provided. |
| **Note:** GPTAL information may be available on the Antenatal Record Part 1. Confirm data with the woman. | |
| Gravida* | Document the total number of prior and present pregnancies regardless of gestational age, type, time or method of termination/outcome. Twins or multiples are counted as one pregnancy. A blighted ovum and hydatiform 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* | The total number of previous pregnancies with birth occurring between 20 – 36+6 weeks gestation (includes $36^0$ – $36^6$). |
| Abortion – Spontaneous* | Document the total number of previous spontaneous terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 gm. Ectopic pregnancies, missed abortions, blighted ova and hydatiform moles are classified as spontaneous abortions. |

## 1.0 Demographics and Background Information *cont.*

| Item | Description |
|---|---|
| Abortion – Induced* | Document the total number of previous induced terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 gm. |
| Living * | Document the total number of children, who are presently living, the woman has given birth to. Does **not** include current pregnancy. |
| LMP* (Last Menstrual Period) | Document the woman's last normal menstrual period (if known). |
| EDD Dates<br>(Expected Date of Delivery by dates) | Document the expected date of delivery by using the last normal menstrual period date (if known). |
| US - Ultrasound (EDD) Expected Date of Delivery by | Document the expected date of the delivery, confirmed by the initial ultrasound EDD by US done at <20 weeks gestational age. |
| Gestational age | Document the gestation age including the number of weeks and days from LMP, if known. |

## 2.0 Initial Assessment

| Item | Description |
|---|---|
| Contractions* | Indicate and document as required:<br>• If contractions are present<br>• The date and time contractions started<br>• If contractions are:<br>  ▪ Regular<br>  ▪ Irregular<br>  ▪ Frequency<br>• Intensity – strength of contraction assessed by:<br>  ▪ Asking the woman<br>  ▪ Palpating the fundus during the contraction<br>  ▪ Document as:<br>  • Mild<br>  • Moderate<br>  • Strong<br>• Duration – length of time in seconds the contraction lasts, from the beginning to the end assessed by:<br>  ▪ Asking the woman<br>  ▪ Palpating the fundus during the contraction (i.e. 45 - 60 sec.) |

| Item | Description |
|---|---|
| Membranes* | Ask the woman and indicate if membranes are:<br>• Intact<br>• Ruptured – Document:<br>  ▪ Date<br>  ▪ Time<br>  ▪ Colour (of the amniotic fluid):<br>  • Clear<br>  • Meconium stained<br>  • Bloody<br>• Query – may need to be confirmed:<br>  ▪ With Nitrazine paper<br>  ▪ From a sterile speculum exam – testing for Ferning |
| Bleeding | Ask the woman and indicate if bleeding or show is present and document:<br>• Date and time bleeding started<br>• Amount: (may need to weigh peripad, 1 gm = 1 ml)<br>  ▪ Scant<br>  ▪ Small<br>  ▪ Moderate<br>  ▪ Large<br>• Colour/consistency – for example bright red, mucousy |
| Fetal Movement | Indicate the woman's awareness of fetal movement as (document date and time noted):<br>• Normal<br>• ↑ = Increased<br>• ↓ = Decreased |
| Infectious History | Indicate if the woman has had any recent infectious disease/ contact by No/Yes and if Yes, specify:<br>For example:<br>• MRSA (Methicillin Resistant Staphalococcus Aureus)<br>• VRE (Vancomycin Resistant Enterococcus)<br>• Chicken pox<br>• Hep B (Hepatitis B)<br>• TB (Tuberculosis)<br>• HSV (Herpes Simplex Virus) |
| Antibiotic Resistant Organism (ARO) Screen | Indicate if the woman has had an Antibiotic Resistant Organism Screen; include your initials. Complete an ARO screen as per institutional policy. |
| Triaged as<br>*Refer to DST No.1:*<br>*Obstetrical Triage and Assessment* | Use the priority code to determine urgency for assessment and care as:<br>• Emergent<br>• Urgent<br>• Non-urgent |

## 2.0 Initial Assessment *cont.*

| Item | Description |
|---|---|
| Triaged to | Indicate where the woman was triaged:<br>• LDR (Labour and Delivery Room)<br>• Assessment room<br>• Waiting room<br>• Other - specify |

## 3.0 History/Risk Factors

| Item | Description |
|---|---|
| Antenatal Records Part 1 & 2 | Indicate if the Antenatal Record was reviewed or not available:<br>• If the information is on the antenatal record document "See Antenatal Record" in the pertinent sections.<br>• If the records are not available, complete the sections (of the History/Risk Factors) below. |
| Allergies | If Yes specify allergies and any reactions. |
| ABO Group__ Rh__* | Document the ABO or Rh blood typing and red cell antibody screening. |
| GBS result* (Group B Streptococcus) | Indicate the unknown, positive or negative result(s) of Group B Strep screening from an anorectal culture at 35-37 weeks gestation. Indicate if swabs were taken at this visit. Document the date the last swab was done. |
| Current medications/complimentary therapy | Indicate if the woman is taking:<br>• Vitamins only.<br>• Other medications - document the type of medication, and when the last dose of medication was taken.<br>Indicate if medication history is recorded on an institutional Medication Reconciliation Form. |
| Height cm/ft-in* | Document the woman's height in centimetres (preferably). |
| Pre-pregnant weight kg/lb* | Document the woman's pre-pregnant weight in kilograms (preferably). |
| Pre-pregnant BMI<br>(Chart available on Antenatal Record) | Document the pre-pregnant BMI of the woman in kilograms (preferably).<br>Formula - BMI ($kg/m^2$) = Weight in kg/Height in $metres^2$. |
| Current weight kg/lb* | Document the woman's current weight in kilograms (preferably). |
| Weight gain kg/ lb* | Document the woman's pregnancy weight gain in kilograms (preferably). |
| Pregnancy concerns* | Indicate if the woman has any pertinent pregnancy concerns. If yes, specify as required. |

## 3.0 History/Risk Factors *cont.*

| Item | Description |
|---|---|
| Past obstetric concerns<br>None, Yes, specify* | Indicate if the woman has any pertinent past obstetrical concerns. If yes, specify as required. |
| Medical/Surgical/Anaesthetic concerns* | Indicate if the woman has any pertinent medical/surgical/ anesthetic concerns. If yes, specify as required. |
| Psychosocial Concerns* | Indicate if the woman has any pertinent psychosocial concerns such as substance use, mental health and current tobacco use including the number of cigarettes per day or the date she quit. For more information on tobacco use and support for quitting, please refer to the BCPHP Guidelines for Maternal Postpartum Care. |
| Previous admission this pregnancy* | Indicate if the woman has had a previous admission this pregnancy (this includes if she has had a previous NST). If yes, please specify the reason. |

## 4.0 Assessment

| 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 had fluids. |
| Symphysis Fundal Height consistent with gestational age | Indicate if the SFH is consistent with gestational age. For SFH trends from antenatal visits refer to the Antenatal Part 2, section 16 (if available). If SFH is not consistent with stated gestational age, document SFH in cms. |
| Presentation* | Part of the fetus that enters the pelvis first. Perform Leopold's Manoeuvres to determine fetal presentation. For more than one fetus you may want to use a cross (+) to indicate where on the abdomen the heart sounds are heard.<br>Document as:<br>• Cephalic (head) – 96% of births<br>• Breech (buttocks or feet first) – 3% of births<br>• Shoulder – 1% of births |
| Lie* | The relation of the long axis (spine) of the fetus to the long axis (spine) of the mother. Document the lie of the fetus as:<br>• Longitudinal (Vertical)<br>• Transverse (Horizontal)<br>• Oblique |

## 4.0 Assessment *cont.*

| Item | Description |
|---|---|
| Position* | The relation of the presenting part (occiput, sacrum, mentum [chin], or sinciput [deflexed vertex) to the 4 quadrants of the mother's pelvis – denoted by a 3 part abbreviation. Document the position of the fetus.<br>For example:<br>• LOA – Left Occipital Anterior<br>• RSP – Right Sacrum Posterior<br>• LOT – Left Occipital Transverse (lateral) |
| Engaged* | The largest transverse diameter of the presenting part (usually the biparietal diameter) has passed through the maternal pelvic brim. Indicate if the presenting part is engaged. |
| FH (Fetal Heart) assessment mode* | Indicate the method used to obtain the FH:<br>• AUSC Intermittent Auscultation (IA)<br>• EFM (Electronic Fetal Monitoring)* – if used, specify reason<br>• NST (Non Stress Test) – if performed, specify reason |
| **Note:** For FHR (Fetal Heart Rate) refer to Decision Support Tool No. 2: Intrapartum Fetal Health Surveillance | |
| FHR [bpm] | For FHR document the time and:<br>• Baseline in bpm (for IA and EFM) – normal 110 – 160 bpm<br>• Rhythm for IA (Intermittent Auscultation) – regular, irregular<br>• Variability for EFM (Electric Fetal Monitoring):<br>▪ Absent<br>▪ ≤ 5 bpm (Minimal)<br>▪ 6 – 25 bmp (Moderate)<br>▪ > 25 bpm (Marked)<br>• Accelerations - document accelerations as:<br>▪ √ = Present/Spontaneous<br>▪ ø = Absent/Not heard<br>▪ SS = Present/Scalp stimulation<br>• Decelerations - document decelerations as:<br>▪ √ = Present<br>▪ ø = Absent/Not heard<br>▪ If using EFM, document type of decelerations:<br>• E = Early<br>• V = Variable*<br>• L = Late*<br>• P = Prolonged*<br>• Describe decelerations in terms of ↓ __ bpm x ___ sec/min in Interprofessional Progress Notes<br>▪ Document interventions and evaluation of interventions<br>• Classify FH tracing(s) as:<br>▪ N (Normal)<br>▪ ATYP (Atypical)<br>▪ ABN (Abnormal) |

<table>
<tr><th>Item</th><th>Description</th></tr>
<tr><td>MATERNAL (Assessment)*</td><td>Document the time the maternal assessment was performed including:<ul><li>Contractions - document frequency, intensity and duration if contractions are present</li><li>BP (Blood Pressure)</li><li>Pulse</li><li>Temperature</li><li>Respirations</li><li>Urine P/K:<ul><li>Protein - Neg (Negative), Trace, +1, +2, +3</li><li>K (Ketones) - Neg (Negative), Trace, +1, +2, +3</li></ul>Note: Check Protein and Ketone test strips for specific values equivalent to 1+, 2+, 3+</li><li>Blood sugar – the blood sugar reading from the blood test from the glucometer machine</li></ul></td></tr>
<tr><td>INITIALS</td><td>Provide legible initials.</td></tr>
<tr><td>VAGINAL EXAM*</td><td>Indicate the time the vaginal exam was performed for the vaginal exam document:<ul><li>Dilatation in cm</li><li>Length in cm</li><li>Station of the presenting part (from -3 – +3)</li><li>Cx (Cervix) Position (Anterior, Mid, Posterior)</li><li>Cx Consistency (Soft, Medium, Firm)</li></ul></td></tr>
<tr><td>EXAMINED BY</td><td>Provide signature of person completing section.</td></tr>
<tr><td>TESTS<br>Bishop Score*</td><td>Document the Bishop score if the woman is being assessed prior to induction. The Bishop score is assigned based on the assessment of cervical dilation, length, position, consistency and fetal station. Refer to BCPHP Obstetric Guideline 1 Cervical Ripening and Induction of Labour:<br><br><table><tr><th>Criteria</th><th colspan="3">Points Assigned</th></tr><tr><th></th><th>0</th><th>1</th><th>2</th></tr><tr><td>Dilation</td><td>0</td><td>1-2 cm</td><td>3-4 cm</td></tr><tr><td>Effacement</td><td>0-30%</td><td>40-50%</td><td>60-70%</td></tr><tr><td>Cervical Length</td><td>>3 cm</td><td>1-3 cm</td><td><1 cm</td></tr><tr><td>Consistency</td><td>Firm</td><td>Medium</td><td>Soft</td></tr><tr><td>Position</td><td>Posterior</td><td>Mid</td><td>Anterior</td></tr><tr><td>Station</td><td>-3</td><td>-2</td><td>-1 to ≥0</td></tr></table></td></tr>
<tr><td>Amniotic Fluid Nitrazine*</td><td><ul><li>Indicate if Nitrazine paper (pH paper) was used to confirm rupture of the membranes and indicate the results. Document in Interprofessional Progress Notes if a sterile speculum was performed.</li></ul></td></tr>
</table>

## 4.0 Assessment *cont.*

| Item | Description |
|---|---|
| Ferning* | Indicate if a sterile speculum exam was performed to obtain a sample of amniotic fluid for the ferning test and indicate the results. Document in Interprofessional Progress Notes if a sterile speculum was performed. |
| Swabs done<br>fFN, C&S Other | Indicate if a sterile speculum exam was performed for:<br>• fFN (Fetal Fibronectin) test for a woman with threatened preterm labour and document the results<br>• C&S (Culture and sensitivity) test for infection/vaginal discharge<br>• Other swabs – specify the test |
| Urine sent | Indicate if a urine specimen was sent for:<br>• R&M (Routine and microbiology)<br>• C&S (Culture and sensitivity) |
| Blood work | Document and specify if any blood tests were ordered and performed. |
| Provider Name ___arrived at __h | Record the name of the health care provider (HCP) and the time s/he arrived. |
| Notified by ___ at | Record the name of the person who notified the HCP and the time the notification took place. |
| Completed by___<br>Signature | Provide signature of person completing section. |

## 5.0 Interprofessional Progress Notes

| Item | Description |
|---|---|
| Date/Time | Record date and time. |
| Focus | Indicate the reason (focus) for documentation. |
| Interprofessional Progress Notes | Document in a chronological order any pertinent information and variances obtained during the maternal/fetal health assessment. |

## 6.0 Teaching/Follow-Up

| Item | Description |
|---|---|
| Teaching/Follow-up | Indicate if the woman was instructed and supported for:<br>• Fetal Movement Count (may provide Fetal Movement Count record)<br>• Labour<br>• When to call/return to hospital<br>• NST (Non-stress Test)<br>• BPP (Biophysical Profile)<br>• Ultrasound<br>• Office Visit<br>• Induction List – document the specifics (e.g. reason, method, date and time) concerning the induction<br>• Care plan – indicate if an advanced care plan has been developed<br>• Research – indicate if the woman is a candidate for or has been enrolled in a particular research study<br>• Other |

## 7.0 Referrals

| Item | Description |
|---|---|
| Referrals | Indicate referrals and document the specific discipline or service.<br>For example: social work, anesthesia |

## 8.0 Status

| Item | Description |
|---|---|
| Admit to, Discharged to, or Transferred to | Indicate the date and time and whether the woman was (select one only):<br>• Admitted<br>• Discharge<br>• Transferred |

## References

BC Perinatal Health Program (2009). Core Competencies: Management of Labour in An Institutional Setting if the Maternal Primary Care Provider is Absent. Guidelines for Registered Nurses. Vancouver, BC: BCPHP.

Lowdermilk, D. L. & Perry, S. E. (2007). Maternity & Women's Health Care (9th ed.). St. Louis, MI: Mosby

BCPHP (2005). Obstetric Guideline 1 Cervical Ripening and Induction of Labour. Vancouver, BCPHP.

**Obtaining copies of the BC Perinatal Triage and Assessment (PTA) Record**

- 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

**Members of the BC Perinatal Triage and Assessment (PTA) Record Revision Committee:**

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

| | |
|---|---|
| Lily Lee | Perinatal Nurse Consultant, BCPHP, Project Lead |
| Laurie Seymour | Project Consultant and Facilitator |
| Laura Bailey | Provincial Perinatal Analyst, BCPHP |
| Lyn Jones | Clinical Resource Nurse, Maternity, Richmond |
| Janet Scott | Perinatal Staff Nurse, Richmond |
| Connie Harborne | Educator, Powell River |
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## Notes

## Notes


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