Perinatal Forms Guideline 9
A Guide for Completion of the British Columbia Postpartum Clinical Path (PSBC 1592)

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

Introduction

The revised British Columbia Maternal Postpartum Clinical Path has been developed to facilitate the assessment and documentation of pertinent information of postpartum women in a structured, logical and standardized manner. It is a form to facilitate consistent and complete documentation, communication, and continuity of care among health care providers and provides a guide for evidence-based postpartum care. Specific fields from the entire suite of Provincial Perinatal Forms are collected as part of a comprehensive database for Perinatal Services BC (PSBC) Database Registry. Information collected for the Perinatal Database Registry is identified by an asterisk (*). In the Postpartum Clinical Path breastfeeding information is collected in the perinatal database registry and is identified with an asterisk (*) in the Guide for Completion. The mandate of PSBC includes the collection and analysis of perinatal data to evaluate provincial perinatal outcomes, and to improve health care initiatives.

Guiding Principles

The BC Postpartum Clinical Path is designed for use in conjunction with the Postpartum Nursing Care Pathway, the Newborn Nursing Care Pathway and the BC Newborn Clinical Path.

Several key principles guided the design and development:

- Be applicable for all maternity hospitals providing postpartum care
- Incorporate relevant information from the 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 condition(s)
- Seamless integration of other provincial records such as the Labour Partogram, Birth Summary, Newborn Record and Newborn Clinical Path as much as possible
- Facilitate data collection for Perinatal Services BC Perinatal Database
- Enable electronic archiving or formatting

General Guidelines

Specific guidelines are relevant to all sections of the Maternal Postpartum Clinical Path

- To determine the specifics of the normal and normal variations, variances, interventions client teaching and anticipatory guidance, and frequency of assessments, utilize the PSBC Postpartum Nursing Care Pathway as the foundation for documentation

- To obtain pertinent information
  - Confirm assessment data with the woman
  - Review Antenatal and Triage Assessment Records, Partogram, Labour and Birth Summary, and any other significant health records
  - Perform a maternal physical and psychosocial assessment referred to as Nursing Assessment

- For any identified variances
  - Document in the Variance Record/ Progress Notes
  - Communicate with the Primary Health Care Provider (PHCP) or designate prn:
    - Exact time of notification
    - Nature of communication
    - Response of PHCP
    - Plan of action
    - Response or evaluation of outcome

- A blank space or 'X' indicates that the action or assessment was not performed

The following sections provide descriptive information on the items on the Postpartum Clinical Path

- The term "Document" instructs one to write out the requested information in the space provided
- The term "Indicate" instructs one to check (√) the box provided
- Under the "Item" column fields collected in the database are identified with an asterisk (*)

1.0 Birth Summary

Item	Description
Addressograph/label area	Demographic information includes: patient surname, given name, address, phone number, personal health number, physician/midwife name and date
Gravida	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. Refer to British Columbia (BC) Antenatal Record Part 1, Section 3 (PSBC 1582) or the BC Labour and Birth Summary Record, Section 1 (PSBC 1588)
Term	The total number of previous pregnancies with birth occurring at greater than 37+0 weeks gestation (includes 37^0 – 37^6). Refer to British Columbia (BC) Antenatal Record Part 1, Section 3 (PSBC 1582) or the BC Labour and Birth Summary Record, Section 1 (PSBC 1588)
Preterm	The total number of previous pregnancies with birth occurring between 20 – 36+6 weeks gestation (includes 36^0 – 36^6). Refer to British Columbia (BC) Antenatal Record Part 1, Section 3 (PSBC 1582) or the BC Labour and Birth Summary Record, Section 1 (PSBC 1588)
Abortion	Spontaneous: 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. And Induced: The total number of previous induced terminations of pregnancies ending prior to 20 completed weeks gestation and weighing less than 500 gm Refer to British Columbia (BC) Antenatal Record Part 1, Section 3 (PSBC 1582) or BC Labour and Birth Summary Record, Section 1 (PSBC 1588)
Living	The total number of children the woman has given birth to, who are presently living. Does **not** include current pregnancy. Refer to British Columbia (BC) Antenatal Record Part 1, Section 3 (PSBC 1582) or BC Labour and Birth Summary Record, Section 1 (PSBC 1588)
Birth date (of infant) and time	Document the newborn's birth information as: date of birth (dd/mm/yy), and time of birth Refer to the BC Newborn Record Part 1, Section 4 (PSBC 1583) or from the BC Labour and Birth Summary Record, Section 5 (PSBC 1588)
Delivery	• Indicate the type of delivery Spontaneous Vaginal Delivery (SVD), Vacuum (Assisted Birth), Forceps (Assisted Birth). • Caesarean Section (C/S): emergent or elective Refer to the BC Labour and Birth Summary Record, Section 4 (PSBC 1588)

1.0 Birth Summary, *cont.*

Item	Description

Perineum	Indicate the condition of the perineum as:
	• Intact
	• Laceration
	  ▪ Document degree:
	  • *First* - extends through the skin and structures superficial to muscles
	  • *Second* – extends through muscles of the perineal body
	  • *Third* – continues through the anal sphincter muscle
	  • *Fourth* – also involves the anterior rectal wall
	  Reference: Lowdermilk & Perry, 2007, p. 565
	• Episiotomy
	Refer to the BC Labour and Birth Summary Record, Section 4 (BCPHP HLTH 1588)

Blood loss (Refer to DST on Postpartum haemorrhage)	Indicate the estimated volume of blood loss in the intrapartum episode of care as: 500 -1000 ml > 1000 ml Refer to the BC Labour and Birth Summary Record, Section 4 (PSBC 1588)
Epidural catheter removed	Note if not applicable. If applicable document removal of epidural catheter. Include: date, time • Provide a legible signature • Indicate if the epidural catheter was intact: Yes or no
Allergies	If yes, indicate if the woman has any known allergies • NKA (no known allergies) • If yes, specifiy the allergy and reaction Refer to the BC Antenatal Record Part 1, Section 2 (PSBC 1582) or the BC Labour Partogram, Section 1 (PSBC 1583)

2.0 Clinical Observation

Frequency of observations **–** Follow the organization's policy for Maternal Care. The suggested frequency of observations after completion of third stage are:

Vaginal Birth	Caesarean Birth
Every 15 minutes X4 (Temperature once in first hour)	Recovery Room record X 4 (Temperature once in first hour) • RR/sedation q1h X 12hr (refer to spinal/epidural anaesthetic orders)
At 2 hours	
Once per shift until discharge	At 2 hours
	Q 4h X 24 hrs
	Once per shift until discharge

Variances –

- Require more frequent observations as appropriate
- Describe any variances in the Variance Record/Progress Notes (including focus, information on the variance, nursing actions and responses to interventions/care)

Item	Description
Date/Time	Document the date and time the clinical observations/assessments were performed
Blood pressure	In the appropriate date and time column, on the appropriate line, use the symbol "∨" to indicate the woman's systolic blood pressure and the symbol "∧" to indicate the woman's diastolic blood pressure. Blood pressures 140 systolic and 90 diastolic are highlighted with dotted lines with documented measurements between the lines within normal limits. More severe BP boundaries at **160** systolic and **110** diastolic are highlighted in **bold** text. This triggers an alert that includes further assessments and notification of the PCHP for BP variances outside of the normal range.
Pulse	In the appropriate date and time column, on the appropriate line, use the symbol " • " , to indicate the woman's pulse.
Temp	In the appropriate date and time column, on the appropriate line, 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 PHCP notification for temperature variances outside of the normal range
Respiratory rate	Document the respiratory rate (counted for one minute, if relevant).
O_2 sat	Document Oxygen saturation (if relevant).

2.0 Clinical Observation, *cont.*

Item	Description

Sedation scale	As per legend, document the:
	• 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
	• Normal sleep is documented as 3.
	• For a score of 5 or more the attending physician/anesthesiologist should be called
	
	Adapted from Wilson Sedation Scale Score (Nemethy et. al. 2002)

Pain	As per legend, document the:
	• Pain Scale from 0–10
	  ▪ 0 = No pain
	  ▪ 10 = Worst pain possible

Fundal tone	As per legend, indicate the tone of the fundus as: F = Firm, M = Firm with massage or B = Boggy.
Fundal height	As per legend, indicate the height of the fundus as: 0 = (At the level of the) umbilicus, ↑ = Above the umbilicus, ↓ = below the umbilicus, (generally noted in finger widths)
Lochia – amount	As per legend, indicate the amount of the lochia as: Sc = Scant, S = Small, M = Moderate, H = Heavy or CL = Clots
Lochia colour	As per legend, indicate the colour of the lochia as: R = Rubra, S = Serosa or A = Alba.
Abdominal incision	As per legend, indicate the condition of the abdominal incision as: N/A = Not applicable, DI = (Dressing) Dressing dry and intact, Oz = Dressing oozing, H = Wound healing, DR = Dressing removed, S/R = Sutures/staples removed.
Initials	Provide legible initials

3.0 Maternal Assessment

Refer to the timeframes in the Postpartum Nursing Care Pathway for a description of the normal/normal variations, client education and anticipatory guidance, variances and interventions for each of the assessed items.

- Assessments performed:
  - During the period of stability
  - Once per shift until discharge

Variances

Require more frequent assessments as required

- Describe any variances/concerns in the Variance Record/Progress Notes (including focus, information on the variance, nursing actions and responses to interventions/care)

Item	Description
Instructions/legend	As per the instructions: Put a checkmark (√) in the appropriate column • N = Normal • V = Variances or concerns **Note:** record the variances/concerns on the Variance Record/Progress Notes Document in the "N" column • NA = Not applicable • X = Not assessed
(Intravenous) IV	If applicable indicate if the woman has an IV • N/A Not applicable • Yes Document when the IV was discontinued by: • Date • Time • Provide a legible signature Refer to BC Labour Partogram, Section 10, (PSBC 1583) and/or a separate I&O record in the maternal chart.
Foley catheter removed	If applicable document the removal of the foley catheter. Include: • Date • Time • Provide a legible signature Document the first void as: • Date • Time • Amount
Date/Time	Document the date and time the clinical observations/assessments were performed.

3.0 Maternal Assessment, *cont.*

Item	Description
Hours postpartum up to 72, then # of days	Document the postpartum time in hours. Once the woman is 72 hours postpartum (3 days) document the timeframe in days.
Normal/Variance Columns (N/V Columns)	Indicate Normal or Variance for each of the areas relating to the maternal postpartum assessment as per the BC Postpartum Nursing Care Pathway. Place a checkmark (√) in the • **N** column indicating the assessment fits the normal or normal variations for the time period as described in the Postpartum Nursing Care Pathway • **V** column indicating there is a variance from the assessment for the time period as described in the Postpartum Nursing Care Pathway The comprehensive maternal postpartum assessment includes: • Breasts • Breastfeeding • Skin-to-skin • Responds to newborn feeding cues • Hand expression/pumping • Perineum • Urinary function • Bowel function • Healthy eating • Adequate intake/output • Activity/Rest • Emotional status and mental health • Bonding and attachment • Family function • Tobacco use • Alcohol • Substance use • Falls Risk Screen ▪ Reviewed and no concern for falling – check normal (N). ▪ Reviewed and at risk for falling – check variance (V) and document risk and write plan in Progress Notes. ▪ Complete a Falls Prevention Care Plan as required for your site.
Other	• Other significant assessment criteria that are not listed above are documented in this space. Put a check mark (√) in the **N** column if the woman is stable **V** = if unstable and document observations in the Variance Record/Progress Notes. For example: ▪ Hypertension in pregnancy ▪ Diabetes ▪ Communicable diseases such as Hep C, Hep B, HIV ▪ Surgical procedures (excluding C/S) such as hysterectomy, ▪ Procedures such as epidural headache treatment
Initials	Provide legible initials

4.0 Summary, Education / Anticipatory Guidance

Item	Description
Interpretation required / Language	Indicate if interpretation is required and the language required for provision of care.
Education (Item) Initials, N/A (not applicable)	Prior to discharge from the hospital, the following items are to be reviewed with the woman If the item is not applicable put a check mark (√) on the row in the column N/A (not applicable) Space is provided for each item to be reviewed with the woman more than once (including the initials of the person performing the assessment) For any variances the woman should be included in the plan and the PHCP and/or referrals have been contacted • Review the following: 1. Breast, nipple care, management of engorgement 2. Knows how to hand express milk 3. Recognizes and responds to infant feeding cues, behaviours 4. Recognizes effective feeding and milk transfer 5. For infants fed breastmilk substitute: appropriate formula, preparation and storage 6. Normal physiological changes/care, fundus & flow, incision 7. Voiding & bowel patterns 8. Self-care hygiene, pericare 9. Pain management/ options 10. S&S for follow-up (e.g. fever, infection, overly drowsy) 11. Prescription/self medication/ medication reconciliation 12. Activity and rest 13. Healthy eating 14. Postpartum blues/ depression 15. Family planning/ sexuality 16. Support systems in place 17. Access to *Baby's Best Chance* Parents' Handbook 18. Tests and procedures ▪ Rubella status ▪ MMR given (if applicable), date and initials of giver ▪ Rh Immune Globulin given (if applicable), date, time and initials of giver ▪ Other — such as blood work for maternal conditions (e.g. PPH, PIH, infection) 19. Tobacco cessation/ exposure to second-hand smoke 20. Review of communicable diseases 21. Knows who primary health care provider (PHCP) is, how to access & when to contact 22. Aware of PHN contact/role/community resources 23. Ready for hospital discharge, discharge order
Variances – Plan(s)	Document the identified variance(s) including the plan(s) for resolving the variances; include information regarding any referrals (such as specialist, clinics, etc.).

5.0 Discharge

Item	Description
Postpartum hours/days at discharge	Document how many postpartum hours/days the woman was at the time of discharge • ≤72 hours – document in hours • ≥ 72 hours – document in days
Home with baby	Indicate if the mother was discharged home with her baby
Liaison completed	Indicate if the Community Liaison Record was completed
Hospital discharge: Date Time	Document the date and time of discharge
Signature	Provide a legible signature

6.0 Variance Record / Progress Notes

Item	Description
Date/Time	Record date and time
Focus	Document the reason or focus of documentation
Variances/ Progress Notes	Document in a chronological order any variances observed during the postpartum maternal assessment. Ensure to include pertinent data, nursing actions or plan of care, and responses or evaluations of outcomes

References

Perinatal Services BC (PSBC) & the College of Registered Nurses of BC (CRNBC) (2009). Core Competencies: Management of Labour in An Institutional Setting if the Maternal Primary Care Provider is absent. *Guidelines for Registered Nurses.* PSBC.

Perinatal Services BC (PSBC) & the College of Registered Nurses of BC (CRNBC) (2009). Decision Support Tools (DSTs). PSBC.

Evans, RJ, Evans MK, Brown YM, Orshan SA (2010). *Canadian Maternity, Newborn, & Women's Health Nursing*. Philadelphia PA: Lippincott Williams & Wilkins.

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

Society of Obstetrician and Gynaecologists of Canada. (SOGC).

Obtaining copies of the BC Postpartum Clinical Path

- Individual practitioners may obtain copies of the forms from the local hospital.
- Facilities will order forms through RR Donnelley. Refer to PSBC website link **http://www.perinatalservicesbc.ca/Forms.htm** for the order form.
- Contact the Perinatal Services BC (PSBC) at 604.877.2121 regarding any feedback or questions about the perinatal forms.

Revision Committee

Members of the Postpartum Clinical Path Revision Committee

Perinatal Services BC (PSBC) would like to acknowledge the working committee who revised the BC Postpartum Clinical Path. Committee members included:

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