

MATERNITY CASE RECORD GUIDELINES

DEPARTMENT OF HEALTH

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GUIDELINES FOR THE MATERNITY CASE RECORD

BACKGROUND/INTRODUCTION

The First Interim Report on Confidential Enquiries into Maternal Deaths in South Africa has revealed amongst others, problems which have special reference to medical personnel which include incorrect diagnosis, incomplete assessment of the patient and non utilisation of the partogram.

The maternity case record was developed with realization that different institutions use different case records within one Province. In addition the partogram is incorrectly used or not used at all and is actually not part of the maternity case record in some places. As a result useful information is not recorded and it is not clear whether this is out of negligence or information is not captured in the existant case records.

The maternity case record is standardized for use by all facilities conducting deliveries in South Africa. It is meant to provide a comprehensive record that will be used uniformly and fill the gaps in the existing documents. It is envisaged that use of the case record will overcome the unnecessary delay of action/intervention when a woman is in labour. It need not be emphasized that early problem recognition during labour will lead to prompt management. (One case record used by all levels of care).

The case record is for use not only for patients in labour but also for all women requiring admission in general. It will be facility kept and a discharge summary will be provided after delivery of the woman on discharge. It is designed in such a way that it should be easy to add additional paper in case of need (clinical notes for those that stay long in hospital/repeated admissions in the ANC period, partogram in case of spoiled paper, labour initial assessment for those that may have been admitted with false labour and come again in established labour etc). Each person making entries in the Maternity Case Record should write their names in full together with their signatures after each entry.

This manual is a guideline on use of the Maternity Case Record.

DESIGN

The record has the following sections:

1.	Personal details	1
2.	Antenatal details	2
3.	Clinical notes	3 –5, 10 & 13
4.	Midwife observation chart	6
5.	Labour – Initial assessment	7
6.	The Partogram	8-9
7.	Forceps delivery/Vacuum extraction	11
8.	Caesarean section	12
9.	Summary of labour	13
10.	Assessment of the newborn	15
11.	Puerperium: Notes/Procedures	16-17
12.	Control chart: Puerperium	18
13.	Discharge summary	19 & 20*
14.	List of abbreviations	21*

The design throughout the record is such that a check list is provided to prompt/remind health workers to elicit the information. Wherever possible different options are provided which require the health provider to tick the appropriate response. Space is provided for detail (description, instructions etc.) whenever there is need. All parts must be completed.

PERSONAL DETAILS

Page 1 of the document provides the personal details of the patient, information about the facility and previous admissions in the current pregnancy. Information on the facility is important especially in referral cases. Personal details of the patient will facilitate tracing of the relatives in cases of mishaps or if there is need for more information or urgent referral to another institution. The last section provides a summary of problems existant in the current pregnancy even before one starts paging through the case notes.

Classification of institutions

1. CHC - Community Health Centre
2. Level 1 Hospital - hospitals staffed by doctors generally with or without visiting obstetric and gynecology specialists
3. Level 2 Hospital - the hospital has obstetric and gynecology specialists that are always available
4. Level 3 Hospital - the hospital has sub-specialists and full time intensive care facilities.

Province _____	District _____	Clinic / Hospital No: _____		
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;"> Clinic CHC </td> <td style="width: 50%; text-align: center;"> Hospital I / II / III </td> </tr> </table>	Clinic CHC	Hospital I / II / III	Name of Institution: _____ _____	Firm/Unit: _____
Clinic CHC	Hospital I / II / III			
Medical Aid _____	Member's Name _____	No: _____		
Name: _____	Race _____			
ID No. _____	Marital Status: _____	Age: _____		
Religion: _____	Occupation: _____			
Address: _____	Tel: (Home) _____			
Residential: _____	(Work) _____			
	(Cell) _____			
	Postal Code: _____			
Postal: _____				
	Postal Code: _____			
Contact Person: _____	Relation to Patient: _____			
Address: _____	Tel: (Home) _____			

Postal Code: _____	(Work) _____		
_____	(Cell) _____		
PREVIOUS ADMISSIONS IN THE CURRENT PREGNANCY			
Hospital	Date Admitted	Date Discharged	Diagnosis & Treatment

ANTENATAL DETAILS

Page 2 of the case record should be completed if the woman is unbooked or if the antenatal (ANC) card is not available. If the ANC card is available it can simply be attached to the case record. The information required here is detail about the pregnancy, current history, past obstetric history, gynecological history, family planning history, drug history, past medical and surgical history, family history and social history. The last section provides space for listing antenatal risk factors elicited from the history. Examination findings should be documented on the clinical notes section followed by the management plan which has been decided on. Investigations that should have been carried out at booking should be done including any other investigations that have been decided on.

Definitions

Gravida: the number of times the woman has been pregnant including the current pregnancy

Parity: the number of times the woman delivered a baby of 22 weeks/500g or more, whether alive or dead

Quickening: When fetal movements are first felt (~18 weeks for multigravida, ~20 weeks for primigravida but may vary).

LNMP: Last normal menstrual period (first day of the last normal period)

EDD: estimated date of delivery

Del.: delivery

C/S: Caesarean section

Gest.: gestation

TB: Tuberculosis

Dur.: duration

SB: Stillbirth

Cond.: condition

NND: Neonatal death

Wt.: weight

NOD: non obstetric death

Kg: kilogram

No: number

ANTENATAL DETAILS

** COMPLETE THIS PAGE ONLY IF UNBOOKED OR ANC CARD NOT AVAILABLE*

Parity _____ Gravidity _____ Booking Clinic _____ No. of visits _____

Cycle: Regular _____ Length _____ LNMP _____ EDD _____ Date of Quickening _____

Contraception : Last one used _____

Pregnancy

Planned/Unplanned	Accepted/Not accepted
-------------------	-----------------------

 Remarks: _____

Complaints during this pregnancy _____

Previous C/S : Number _____ Type of C/S _____

Reasons for C/S _____

Complications during C/S _____

Other Operations _____

Previous/Current Illnesses

Asthma	Heart Disease	TB	Diabetes	Hypertension	Other	
--------	---------------	----	----------	--------------	-------	--

Give Details _____

Medication: Present _____
 Past _____
 Allergy _____
 Substance abuse _____

Family-History: multiple pregnancy, congenital abnormalities, DM, HPT, other: _____
 Socio-economic history/transport _____

PREVIOUS PREGNANCIES											
No	Del. Year	Gest. in Weeks	Dur. of Labour	Mode of Del.	Place of Del.	Alive/ SB NND/NOD	Cond. At Del.	Sex	Wt. Kg	Breast Fed/ Duration	Complications

Reason for admission: _____

Referred from/by: _____

RISK FACTORS (From History)

1	_____	4	_____
2	_____	5	_____
3	_____	6	_____

Name: _____ Signature _____ Date _____

CLINICAL NOTES

For women who are not in labour but require admission, pages 3 – 5 provides space for detailed description of findings on examination, management plan and further documentation of findings on review. Additional loose sheets to use as continuation sheets can be used in case of prolonged hospital stay. Always write the patient's name at the top of each additional sheet with date and time.

This space on page 10 under heading, CLINICAL NOTES is provided to document information that cannot be accommodated on the partogram without repeating what is already on the partogram in words as well as recording in detail any unexpected occurrences such as eclampsia, bleeding etc. The same is true for page 14. Additional information on forceps/vacuum delivery, Caesarean section and summary of labour should be recorded on this page.

CLINICAL NOTES

Date/ Time	Remarks
	EXAMINATION FINDINGS IF NOT IN LABOUR

OBSERVATION CHART

This chart is for use in women that have false labour or are in early labour before a diagnosis of established labour is made/confirmed. It provides for documentation of observations made on contractions (strength and frequency), character of the liquor, fetal heart, maternal vital signs, and the volume and biochemistry of urine. Fetal heart abnormalities should also be documented.

Definitions

Freq: frequency

MSL: meconium stained liquor

FH: fetal heart

Resp: respiration

BP: blood pressure

Min.: minutes

Temp: temperature in degrees centigrade

Prot.: protein (indicate +, ++, +++ if present and - if negative)

Ket.: ketones (indicate +, ++, +++ if present and - if negative)

Glu.: glucose (indicate +, ++, +++ if present and -if negative)

Vol.: volume in mls

IF THE DIAGNOSIS OF LABOUR IS DOUBTFUL

OBSERVATION (4 hourly until labour is established)															
Date/Time	Contraction		Liquor			FH	Maternal			Urine				Vaginal Exam.	
	Strength	Freq	Clear	MSL	Blood Stain		Resp/ Pulse	BP	Temp	Prot.	Ket.	Glu.	Vol.	Dilatation	Effacement

LABOUR – INITIAL ASSESSMENT

Information regarding the initial assessment of women in established labour is documented in this section. Risk factors that were picked up in the ANC period and those that were missed should be listed. At the end of the examination it is again important to list all the maternal and fetal risk factors present. Management plan should be clearly outlined in the section provided. If the woman is in established labour, the partogram should be started and the examination findings transferred to the partogram with the times clearly indicated. In situations where it is not clear whether the woman is in labour or not, the Observation Chart should be used to document observations on a 4hourly basis. Observations can be transferred to the partogram once labour is confirmed. If false labour is diagnosed a new labour – Initial Assessment form (as an add on) will have to be used when later admitted in established labour.

Definitions

ROM: rupture of membranes

Bl. Gp: blood group

CVS: cardiovascular system

SFH: symphysio-fundal height

FH: foetal heart

RPR: rapid plasma reagin

MSL: meconium stained liquor

Hb: haemoglobin

HIV: human immunodeficiency virus

Palp: palpation

EFW: estimated foetal weight

Exam: examination

VDRL: venereal disease research laboratory

LABOUR - INITIAL ASSESSMENT									
------------------------------------	--	--	--	--	--	--	--	--	--

CLINICAL HISTORY									
Date		Time		Assessed by					
If Referred	From			Time of referral		Time of Admission			
Reasons for Referral									
Date & Time : onset of		Labour		ROM		Bleeding			
Booked	Yes	No	If No Give reason						
Details	Name of Clinic			Gest. Age at first booking			No. of Visits		
Hb		Bl.Gp		RPR/VDRL		HIV			
Problems at ANC									
Main Complaints/Problems:									

EXAMINATION										
Gen. Exam.	Pulse		BP		Temp		Appearance			
Chest:										
CVS:										
Other Systems:										
ABDOMINAL EXAMINATION										
Gest. Age	By Dates			Palp		SFH		Sonar		
Lie						Level of Head (in fifths)				
Presentation					Attitude					
Liquor	Volume			Normal	EFW					
Contractions	Yes	No	Unsure	<20sec	20-40sec	>40sec	F	Normal	Abnormal	Absent
Type of FH Abnormality										
VAGINAL EXAMINATION										
Speculum	Liquor			Blood			Cervix			
Digital Exam	Cervix	Thick	Thin	Oedematous	Not felt	Application		Good	Poor	
Cervical dilatation				Effacement			Position			

Presentation							Position				Moulding	OP	0	+	++	+++
Station	-3	-2	-1	0	+1	2	3				PP	0	+	++	+++	
Attitude	Well Flexed			Deflexed						Caput	0	+	++	+++		
Liquor	Clear		MSL	Grade		I	II	III	Blood stained			Offensive				
Pelvic Assessment	Adequate						Doubtful			Inadequate						
RISK FACTORS																
Maternal					Fetal					Labour						
SUMMARY / Diagnosis / Management																
Patient to be managed at:				CLINIC								HOSPITAL				

THE PARTOGRAM

The partogram, sometimes referred to as the labour graph is a graphic representation of the progress of labour. It is used to document progress of labour and facilitates demonstration of problems that are likely to occur or have already occurred which may go unnoticed in written notes. It should be used for all women that are admitted in labour at all levels of health care. The top part provides space for documentation of name, age, parity and date when the partogram is started. It is also important to document duration of labour and that of rupture of membranes when the partogram is started. Risk factors identified in the antenatal period and on admission in labour should be listed in the space provided. The idea is to have all the relevant information that will inform management of the patient on one page without having to refer to the ANC card, previous pages and other notes.

The partogram is divided into the latent phase and active phases of labour. The latent phase of labour normally does not exceed 8 hours hence the horizontal line starting at zero hour to 8 hours on the partogram. The **alert line**, the first oblique line, represents the minimum acceptable cervical dilatation rate in the active phase which is 1cm/hour. The second oblique line is the **action line**. Progress of labour is slow if the cervical dilatation graph crosses or falls on the action line and action must be taken to hasten delivery of the baby. If the woman is in a clinic without an advanced midwife in attendance she will have to be referred to a hospital with theater facilities for further management. If an advanced midwife is looking after the woman in labour she/he can augment the labour with oxytocin provided there are no other risk factors and oxytocin is not contraindicated. In a hospital setting decision will also have to be made on whether augmentation with oxytocin should be given or proceed to a caesarean section.

There are four major features on the graph – foetal condition, progress of labour, maternal condition and planned management. Zero time is always taken as the time of admission, however it is important to indicate the time when labour started so as to be alert of the passage of time. Each box on the fetal and maternal conditions sections of the graph represents half an hour whereas each box on the progress of labour section represents an hour.

FOETAL CONDITION

The foetal condition is recorded at the top part of the graph and includes the following:

- The foetal heart pattern
- The state of the liquor
- Degree of moulding.

Foetal heart pattern

The foetal heart section may look different from graphs people may have used in the past. This section is constructed the way it is to facilitate documentation of not only the baseline foetal heart rate but also variability and presence of decelerations. The foetal heart should therefore be assessed before, during and after a contraction. Record the foetal heart rate in the appropriate box and place an X in the appropriate box against variability and

decelerations.

Liquor

The abbreviations defined below should be entered in the appropriate block to indicate the state of the liquor and whether membranes have been ruptured or not.

I	intact membranes
ARM	artificial rupture of membranes
SROM	spontaneous rupture of membranes
C	clear liquor
MSL	meconium stained of liquor
Grade	1 like green tea, is usually not significant (?presence in early labour in primips)
	11 like thin soup, requires close monitoring of labour and CTG where available
	111 like thick porridge and is an indication for delivery as soon as possible

Record presence of meconium stained liquor thus, MSL 1 to indicate presence of meconium stained liquor which look like green tea in the appropriate space.

Meconium aspiration is associated with high perinatal morbidity and mortality, care should be taken to suck the baby as it is delivered to reduce risk of aspiration.

Moulding

Moulding means overlapping of skull bones and this can occur in the sagittal (parieto-parietal) and lamboid (occipito-parietal) sutures. Moulding is normal as the fetus negotiates the birth canal. Moulding of the fetal skull however may indicate presence of cephalo-pelvic disproportion.

Grades of moulding	-	bones normally separated
	+	bones touching
	++	bones overlapping but can be easily separated on digital pressure
	+++	bones overlap and cannot be separated on digital pressure

Moulding should be recorded as a score which is the sum of the moulding in the occipito-parietal sutures and moulding in the parieto-parietal sutures.

Definition of scores

1-3 physiological 4 borderline

5-6 excessive moulding. This together with a head that is 3/5 or more above the pelvic brim indicates presence of severe cephalopelvic disproportion which requires a caesarean section.

Caput

This is swelling of the scalp. The significance of caput especially if severe is in misinterpreting it as descent of the head especially if it extends to the introitus. In this case the level of the head may be interpreted as 0/5 when it may actually be 3/5. CPD is sometimes associated with severe caput.

PROGRESS OF LABOUR

The state of the cervix (dilatation and effacement), descent of the head and strength of contractions are used to monitor progress of labour.

Cervical dilatation and effacement

Effacement (length of cervical canal) is measured in centimeters (cm) and should be indicated by thickening the vertical line according to cm at the appropriate time of entry. Progressive effacement of the cervix is an indicator of progress in the latent phase of labour. An "X" is used to indicate cervical dilatation. A full pelvic assessment should be done at the first examination and findings recorded at the top right corner of the partogram.

Descent of the head

This is expressed as fifths above the pelvic brim:

- 5/5 the head is entirely above the pelvic brim
- 4/5 the head is just entering the brim
- 3/5 the hands can still go partially around the head
- 2/5 the hands splay outwards
- 1/5 only the sinciput can be tipped
- 0/5 the head is entirely in the pelvis.

Descent of the head is indicated by "O" on the graph, big enough to show position of the occiput within the "O" as indicated on the graph.

Uterine contractions

These are recorded by shading the appropriate boxes to indicate the number of contractions in the last 10 minutes, and the strength of the contractions. Each square represents one contraction. If 2 contractions are felt in 10 minutes, 2 squares will be shaded. The strength of the contractions is indicated by putting dots, oblique lines or total shading within the boxes indicating the number of contractions and whether contractions are mild, moderate or strong respectively.

MATERNAL CONDITION

The maternal condition is indicated by the blood pressure (B.P.), temperature, pulse and urine output including the biochemistry of urine and these are entered in the space provided. Indicate B.P. with an upward arrow on systolic level and a downward arrow on the diastolic B.P. these are joined by a vertical line. Pulse is indicated by a dot.

Drugs and intravenous fluids

In this section document the drugs and intravenous fluids the patient is given during labour and the route of administration, e.g. Magnesium Sulphate 5G IM 4 hourly. Oxytocin has a special space to indicate the number of drops given at any one time and change in the drops/minute given.

MANAGEMENT

The lowermost portion of the chart is for recording the problems/risk factors identified as well as the action/magement plan. If the space provided is not enough for outlining the management, this can be continued on page 10. It should however be clearly indicated that further management is detailed on page 10 if the need arises.

EXAMPLE OF A COMPLETED PARTOGRAM

FORCEPS DELIVERY / VACUUM EXTRACTION

In this section documentation of the information on the assisted delivery method used including indications for assisted delivery should be provided. Both the foetal and maternal conditions should be assessed including vaginal examination. Drugs used including analgesia/anaesthesia and the dosages should also be documented.

Appropriate section on delivery should be filled depending on the type of instrument used (forceps/vacuum). Any problems that are experienced with carrying out the procedure should be documented (number of pulls, slippages, leaking etc.). The outcome of both the baby (APGAR, injuries) and the mother (injuries, tears) need to be documented as well.

There is a section for recording post procedure instructions and any other remarks.

Date		Time		Performed By:		Assisted by:							
INDICATIONS:													
CONDITION BEFORE DELIVERY													
Fetal Heart	Normal	Abnormal	Rate				CTG	Yes	No				
Type of FH Abnormality													
Level of Head		Mat. Pulse		BP		Urinary Catheter	Yes	No					
VAGINAL EXAMINATION													
Cervical dilatation		Oedema	Yes	No	Application	Good	Poor						
Level of Head		Position		Flexion		Caput	0	+	++	+++			
Station	3	+2	+1	0	-1	-2	-3	Moulding	OP	0	+	++	+++
Liquor	Clear	MSL	Grade	I	II	III	Blood Stained	PP	0	+	++	+++	
Pelvic Assessment													
Other Findings _____													
DRUGS (including dosage)													
ANAESTHESIA													
General	Local	Epidural	Pudendal	Spinal	Saddle	Other							
Details of problems													

FORCEPS DELIVERY										
Instrument Type		Application	Easy	Difficult	Very Difficult	Failed				
Number of Pulls		Application-Delivery Time								
Comments _____										
VACUUM EXTRACTION										
Cup	Type		Size		Application	Easy	Difficult	Very Difficult	Failed	
No. of Pulls		Strength of traction			Did cup slip?	Yes	No	No. of times cup slipped		
Site of Application				Application-Delivery Interval						
Equipment problems?		Explain _____								
Comments _____										
OUTCOME (FORCEPS OR VACUUM)										
Time Procedure Commenced				Time Completed						
Condition of baby at birth		APGAR	1 min		5 min					
Injuries ?	_____									
Maternal Injuries?	_____									
Comments _____										
REMARKS & POST-PROCEDURAL INSTRUCTIONS										
NAME:					SIGNATURE					
					E:					

CAESAREAN SECTION

Like in the assisted delivery section, indications for Caesarean Section (C/S) should be listed. The conditions of both the mother and the fetus should also be documented. The procedure should be described in detail and findings intra-operative also need to be described in detail. The postoperative management need to be clearly outlined. If the space provided is not adequate this can be continued on page 14 under clinical notes.

CAESAREAN SECTION

INDICATIONS
1

2																			
Date of Op			Time Commenced			Time Completed													
Surgeon				Assistant															
Anaesthetist				Midwife															
OPERATIVE PROCEDURE...																			
PRE-OP DETAILS																			
Date of decision			Time of decision for Op			By whom													
Mat. Pulse		BP		Temp		Level of the Head		Foleys catheter		Yes No									
Pre-Op. Drugs																			
Fetal Heart			Present		Absent		Uncertain		Fetal distress		Yes No								
Give details...																			
OPERATION PROCEDURE AND FINDINGS																			
Anaesthetic		General		Other		Give details													
Problems with Anaesthetic																			
Skin Incision																			
Transverse		Midline		Other		Details													
Uterine Incision		Lower Segment		Classical		DeLee		Other...											
Uterine Scar		Intact		Dehisced		Fetal Presentation			Fetal Position										
Prolonged Incision-Delivery Time			Yes		No		Difficulty with delivery of baby			Yes		No							
Reasons																			
Liquor																			
Increased		Decreased		Clear		MSL		Grade		I		II		III		Blood Stained		Offensive	
Placenta		Upper Segment		Praevia		Anterior		Posterior		Central		Retroplacental Clot			Yes		No		
Other Placental Abnormalities																			
Uterine Abnormalities																			
Uterine Tears... Give Details																			
Tubal ligation		Yes		No		Type...													
Other findings at Op...																			
Closure																			
Drains																			
Further description of operation																			
Estimated Blood Loss																			
Resuscitation of baby			Yes		No		Resuscitated By												
Details of Resuscitation																			
Post-operative Management																			

SUMMARY OF LABOUR

Duration of labour as well as that of ruptured membranes should be noted as it can explain why some complications occurred. Prolonged rupture of membranes can lead to puerperal sepsis and prolonged labour may lead to post partum haemorrhage. Information regarding blood loss is also essential.

Details about the baby should be documented. A guide on assessing the APGAR score is provided for reference.

SECOND STAGE

Time fully Dilated			Bearing Down Began at			Time of Delivery						
Method of Delivery				Delivered by				Assisted by				
Comments												
Complications....												

NEONATE	Male	Female	Alive	FSB	MSB	NND	Weight	ID band on ?	Cord clamp?
1									
2									
Konakion	Yes	No	Eye drops	Yes	No	Type		Given by	
APGAR ASSESSMENT									
APGAR	0	1		2		1 min	5 min		
Heart Rate	Absent	<100 beats/min		>100 beats/min					
Respiration	Absent	Weak cry, slow & irregular respiration <20 min		Good cry					
Muscle Tone	Limp	Some flexion of extremities		Active motion good, flexion of extremities					
Response to stimulation	No response	Grimace		Cry, cough, sneeze or urinate					
Colour	Blue or pale	Body pink, extremities blue		Completely pink					
						APGAR SCORE			

ANESTHESIA

General	Regional	Epidural	Spinal	Saddle	Combination	Local	Pudendal	Perineal	
Given by					Details ...				

SUMMARY OF DURATION OF LABOUR

	ONSET OF LABOUR		DURATION OF LABOUR		MEMBRANES	
	DATE	TIME	HOURS	MINUTES	AROM /	SROM
First Stage					Time of ROM	
Second Stage					Time of delivery	
Third Stage					Dur. of ROM.	
TOTAL DURATION OF LABOUR					Blood loss in mL	

THIRD STAGE

PLACENTA, MEMBRANES & CORD											
Method of Delivery				Umbilical Cord		Normal	Abnormal				
Placenta	Normal	Abnormal	Complete	Incomplete	Membranes	Complete	Incomplete				
Give details...											
Placenta		No. of vessels in Cord		Retroplacental clot		Yes	No	Yes	No		
FOURTH STAGE - Time of observation					Observed by						
Temp		Resp/Pulse		BP		Urine passed	Yes	No	Urinary Catheter	Yes	No
Uterus contracted		Yes	No	Uterus ruptured		Yes	No	Cord/Maternal blood taken		Yes	No
Cervical tears		Yes	No	Give details...							
Perineum	Intact	1 Tear	2 Tear	3 Tear	Episiotomy		Repaired by				
Blood loss		If PPH give details of management...									
Breast feeding initiated		Yes	No	If no give reasons...							

TRANSFER TO WARD BY:

RECEIVED IN WARD BY:

TIME:

Condition satisfactory	Mother	Yes	No	Baby	Yes	No	
Further management, mother and/or baby							

ASSESSMENT OF NEWBORN

Summary of events on resuscitation and problems encountered should be documented in this section. A

checklist is provided for the initial examination of the baby. Tick the appropriate box which will best indicate the state of the baby at the time of examination. This will help determine if there are any congenital abnormalities or conditions that need attention. Appropriate action should be taken in case of abnormalities.

Name _____ Hospital No. _____ D.O.B. _____ Time of Birth _____

RESUSCITATION DETAILS									
No resuscitation required	Oxygen by Mask	Intubation	Tracheal Suction	Drip	Adrenaline	Narcan	Cardiac Massage		
Time Resusc. Commenced		Time Resusc. Completed		Apgar	1 min		5 min		
RESUSCITATION SEQUENCE AND SUMMARY									

PROBLEMS WITH RESUSCITATION (Equipment, staff, etc.)									

INITIAL PHYSICAL ASSESSMENT OF NEWBORN									
Weight	Length	HC	Gest. Age	By obstet Ass.	By Physical Score	Male	Female		
RPR/VDRL	Date taken	Not taken	Positive	Negative	Awaiting Results				
If RPR/VDRL positive ? Action Taken...									
Blood Group	Rh+ve	Rh neg.	Antibodies	Present	Absent				
FIRST EXAMINATION TICK LIST									
General	Well	Sick			General	Well	Sick		
Temperature	36-37 C	>37,5 C	<35,5 C		Legs	Normal	Less than normal		
Appearance	Well nourished	Obese	Thin	Dysmorphic	Feet	Normal	Clubbed		
Odour	Normal	Offensive			Toes	Normal	Abnormal		
Behaviour	Responsive	Lethargic	Irritable	Jittery	Arms	Normal	Not moving		
Head shape	Normal	Asymmetrical	Caput		Fingers	Normal	Fracture		
		Haematoma	Trauma						Abnormal
Fontanelles	Normal	Bulging	Large		Mouth	Normal	Cleft		
		Sunken	Third		Palate	Intact	Cleft		
Colour	Pink	Blue	Pallor		Tongue	Normal	Large		
Heart rate	120-160/min	<120/min	>160/min		Chin	Normal	Protruding		
Resp. rate	40-60/min	Fast >60 min	Slow < 40 min						Small
Recession	Absent	Costal	Sternal		Back	Normal	Meningocoele		
Breath sounds	Quiet	Grunting	Noisy						Sacral dimple
Abdomen	Normal	Distended	Hepatomegaly		Muscle Tone	Normal	Hypertonic		
	Scaphoid	Splenomegaly							Hypotonic
Skin	Intact	Jaundice	Rash		Genitalia	Normal	Ambiguous		
		Bruising	Purpura		Urine	Passed	Not passed		
Cry	Normal	Pustiles			Anus	Patent	Imperforate		
		Hoarse	Absent		Meconium	Passed	Not passed		
Umbilicus	Normal	High-pitched			Eyes	Normal	Abnormal		
		Moist	Mec. Stained		Reflexes	Normal	Abnormal		
		Red	Bleeding						
Assessment									
Assessed by:	Rank:			Signature:					

Supervised by:	Rank:	Signature:
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PUERPERIUM: NOTES / PROCEDURES

Progress in the postnatal period should be documented here including any procedures that are performed in the postnatal period. Both the mother and the baby should be examined daily as long as the mother is in hospital and findings documented accordingly. Indicate if the baby is deceased (SB, NND) or admitted to the neonatal unit if not with the mother under the section on baby.

(Mother and baby)

Date	Time	Remarks	
		MOTHER	BABY

CONTROL CHART: PUERPERIUM

Postpartum observations are charted here 4 hourly or twice daily depending on the condition of the mother. Daily assessment of the following should be carried out: fundal height for normal/abnormal involution of the uterus and tenderness of the uterus; breasts for milk production, state of the nipples and any abnormalities that may interfere with breastfeeding; state of the perineum; character of the lochia especially looking for evidence of infection; passage of urine – some women may have urinary retention following delivery; bowel action; and legs to rule out deep vein thrombosis.

CONTROL CHART: PUERPERIUM												
DAY	DATE	TIME										
Temperature C	40											
	39.5											
	39											
	38.5											
	38											
	37.5											
	37											
	36.5											

Obstetric Problems									
Present Medication									
Discharge Medication									
EXAMINATION ON DISCHARGE									
Looks well	Looks ill	Pulse		BP		Temp		Breasts	
HOF				Vaginal Bleeding	Mild	Moderate	Excessive		
Perineum	Intact	Epis/Tear	Clean	Septic	Urinary Output	Good	Poor	Nil	
Remarks:									
FAMILY PLANNING									
Method discussed	Pill	Injection		IUCD	Condoms	T/L	Vasectomy		
Method accepted	Pill	Injection		IUCD	Condoms	T/L	Vasectomy		
Breast feeding	Discussed		Yes	No	If no explain				
	Initiated successfully		Yes	No	If no explain				
Contraceptive given/performed by									
Remarks:									
BABY									
	Male	Female	Weight	Head circumference	Length	BCG	Polio	Methods of feeding	
1									
2									
Remarks:									
POSTNATAL ADVICE ON DISCHARGE									
Future pregnancies									
Perinatal Care									
Future ANC									
Future mode of delivery									
Future Pap smears/Breast examination									
Postnatal exercises									
Breast Feeding									
Care of the baby									
Immunisation									
Postnatal visit: Date					Clinic/Hospital				
Notification/Registration of Birth									
Name:			Rank:			Signature:			

LIST OF ABBREVIATIONS (is there still need for this?)*

1. ANC - Antenatal Care
2. AROM - Artificial rupture of membranes
3. BCG - Bacille Calmette-Guerin

4. C/S	-	Caesarean section
5. CTG	-	Cardio-tocograph
6. CVS	-	Cardiovascular system
7. DM	-	Diabetes mellitus
8. DOB	-	Date of birth
9. EDD	-	Estimated date of delivery
10. EFW	-	Estimated foetal weight
10. FH	-	Foetal heart
11. FSB	-	Fresh stillbirth
12. Hb	-	Haemoglobin
13. HC	-	Head circumference
14. HIV	-	Human immunodeficiency virus
15. HOF	-	Height of fundus
16. HPT	-	Hypertension
17. IUCD	-	Intrauterine contraceptive device
18. LNMP	-	Last normal menstrual period
19. MSB	-	Macerated stillbirth
20. MSL	-	Meconium staining of liquor
21. NND	-	Neonatal death
22. NOD	-	Non obstetric death
23. OP	-	Occipito-parietal
24. PP	-	Parieto-parietal
25. PPH	-	Post partum haemorrhage
26. Rh	-	Rhesus
27. ROM	-	Rupture of membranes
28. RPR	-	Rapid plasmin reagin
29. SFH	-	Symphysis fundal height

- 30. SROM - Spontaneous rupture of membranes
- 31. TB - Tuberculosis
- 32. VDRL - Venereal disease research laboratory