

<b>Department:</b>	Obstetrics and Gynecology (L&D)		
<b>Document:</b>	Departmental Policy and Procedure		
<b>Title:</b>	Management of Patient Progress at Labor and Delivery		
<b>Applies To:</b>	All Obstetrics and Gynecology Staff		
<b>Preparation Date:</b>	January 08, 2025	<b>Index No:</b>	L&D-DPP-036
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<b>Review Date:</b>	February 22, 2028	<b>No. of Pages:</b>	12

## 1. PURPOSE:

- 1.1 To standardize the health care given to all pregnant women in labour at Labor and Delivery unit (L&D).

## 2. DEFINITIONS:

- 2.1 **Cardiotocography (CTG)**- is a technical means of recording (graphy) the fetal heartbeat (cardio) and the uterine contractions (toco) during pregnancy, typically in the third trimester. The machine used to perform the monitoring is called a cardiotocograph, more commonly known as an electronic fetal monitor.
- 2.2 **Partogram**- is a composite graphical record of key data (maternal and fetal) during labour entered against time on a single sheet of paper. Relevant measurements might include statistics such as cervical dilation, fetal heart rate, duration of labour and vital signs.

## 3. POLICY:

- 3.1 To review the vital signs and to follow the results of all requested investigations within 2 hours of sending samples to laboratory.
- 3.2 To review CTG trace every 15-30 minutes in 1<sup>st</sup> stage; every 5 minutes in 2<sup>nd</sup> stage, patient progress with the midwife every 4 hours with documentation and plotting on the patient's partogram, OR sooner if indicated.
- 3.3 Episiotomies and perineal lacerations not more than 2<sup>nd</sup> degree are to be repaired by residents.
- 3.4 Residents are allowed to perform the certain procedure under supervision by Registrar or consultant including; Caesarean sections, instrumental deliveries and assisted breach deliveries.
- 3.5 At changing of shifts, the residents should review all the cases at L&D before handover to the coming shift.
- 3.6 L&D Residents should inform the registrar immediately if:
  - 3.6.1 Abnormal CTG tracing.
  - 3.6.2 Vaginal examination repeated showing no progress.
  - 3.6.3 Meconium stained liquor.
  - 3.6.4 Cord prolapse or presentation.
  - 3.6.5 Full cervical dilatation with intact membranes and fetal head totally outside the pelvis.
  - 3.6.6 Primigravida in second stage for more than 1 hour or multigravida in the second stage for more than 30 min.
  - 3.6.7 Intrapartum Hemorrhage
  - 3.6.8 Shoulder Dystocia.
  - 3.6.9 Prolonged third stage of labour for more than 30 min.
  - 3.6.10 Incompletely delivered placenta.
  - 3.6.11 Post-partum hemorrhage.
  - 3.6.12 Extended episiotomy or third degree perineal tear and or anal sphincter involvement.
  - 3.6.13 Deviation of maternal vital signs from normal.

3.6.14 Neonatal birth trauma, flat baby, apparent congenital abnormality. NB; The midwife can directly contact the physician regarding any abnormality in patient condition or progress if the Residents are busy or prompt registrar decision is necessary.

3.7 The registrar must inform the senior registrar on duty and discuss lines of management in the following situations:

- 3.7.1 All proposed surgeries.
- 3.7.2 Medically complicated cases.
- 3.7.3 Major deviation from accepted practice.

3.8 The physician should attend (conduct or supervise) the delivery of all high risk cases.

3.9 Toward the end of each shift, the L&D physician should handover all cases to the following shift Physician.

3.10 Senior physician should be present at L&D (when called by L&D physician) for the following:

- 3.10.1 Anticipated difficult caesarean section (e.g Transverse lie with ruptured membranes, dense adhesions, fibroids, etc).
- 3.10.2 Massive haemorrhage.
- 3.10.3 For placenta previa Senior physician should be present in theatre.

#### 4. PROCEDURE:

4.1 Partogram: See P&P Partogram

4.2 Intravenous Fluids:

- 4.2.1 Midwives are responsible for setting up IV fluids and taking blood samples. Labor exceeds 12 hours IV Ringer Lactate should be set up at a rate of 125 ml/h (500 ml/4h).
- 4.2.2 In case of hemorrhage; two IV lines should be set up immediately using 16 gauge IV cannula and crystalloids – Ringer Lactate or 0.9% normal saline to be started.

4.3 Oral Intake:

- 4.3.1 Clear fluids may be allowed in certain circumstances in accordance with specialist advice.
- 4.3.2 Light diet may be allowed one hour after delivery if labour was entirely normal.

4.4 Analgesia: See P&P analgesia in labor.

4.5 Uterine activity Assessment:

- 4.5.1 Palpation and external internal electronic methods can be used to monitor uterine activity. Palpation yields information about frequency (number in 10 minutes), duration (in seconds) and relatively intensity.
- 4.5.2 External monitoring provides a recording of frequency and duration but not the intensity. The sensitivity adjustment of the Cardiotocography to a resting pressure of 10-20 mmHg.
- 4.5.3 The recording gives a relative reading and cannot be used to define actual strength of the contractions. Maternal weight, maternal position during recording of the pattern, maternal and foetal movement and tightness of the belt may all alter the reading.

4.6 Duration of the First Stage:

- 4.6.1 The active first stage usually takes up to 8-12 hours in a primipara and 6-8 hours in multipara.
- 4.6.2 Delay in the established first stage: A diagnosis of delay in the established first stage of labor needs to take into consideration all aspects of progress in labour and should include.
  - 4.6.2.1 Cervical dilatation of less than 2 cm in 4 hours for first labors.
  - 4.6.2.2 Descent and rotation of the fetal head.
  - 4.6.2.3 Changes in the strength, duration and frequency of uterine contractions.

4.7 Duration and definitions of Delay in the Second Stage.

4.7.1 Nulliparous Women:

- 4.7.1.1 Birth would be expected to take place within 3 hours of the start of the active second stage in most women.
- 4.7.1.2 A diagnosis of delay in the active second stage should be made when it has lasted 2 hours and operative delivery should be arranged if vaginal delivery is not imminent women should be referred to a healthcare professional trained to undertake an operative vaginal birth if it is not imminent. Parous women:

- 4.7.1.3 Birth would be expected to take place within 2 hours of the start of the active second stage in the most women.
- 4.7.1.4 A diagnosis of delay in the active second stage should be made when it has lasted 1 hour and operatively delivery should be arranged if vaginal delivery is not imminent woman should be referred to a healthcare professional trained to undertake an operative vaginal birth if it is not imminent.

4.8 Management of Delay in Progress

- 4.8.1 Review of the history and patient records; abdominal palpation for lie, presentation and station; fetal size; and frequency and duration of contraction.
- 4.8.2 Reviewing the FHR recording or Cardiotocograph (CTG) and the color and quality of liquor if membranes have been ruptured. Maternal hydration and analgesia should be reviewed.
- 4.8.3 A vaginal assessment should identify the presentation and, if vertex, the amount of caput and moulding and the position. The station of the leading bony skull and the degree of flexion should be noted along with the assessment of the bony pelvic adequacy.
- 4.8.4 In the grand multiparous women and in women with a uterine scar, the registrar should review the case prior to commencement of oxytocin.
  - 4.8.4.1 The management options are delivery by lower segment Caesarean Section (LSCS) if there is obvious cephalo-pelvic disproportion (CPD) or fetal distress.
  - 4.8.4.2 If uterine activity is inadequate with no contraindication for augmentation, oxytocin infusion should be started according to the protocol aiming at 3-4 contractions/ 10 minutes each lasting for at least 40 seconds with CEFM

4.9 Vaginal Delivery:

- 4.9.1 Low risk cases are to be delivered by midwives.
- 4.9.2 Patient to be delivered by physician:
  - 4.9.2.1 Patient with thick meconium stained liquor.
  - 4.9.2.2 Patients with previous one caesarean section.
  - 4.9.2.3 Patients with clinically suspected big babies.
  - 4.9.2.4 Patient with breech presentation.
  - 4.9.2.5 Patient with twin pregnancy.
  - 4.9.2.6 Patient with prolonged second stage of labour (2 hours or more for prime gravida and more than one hour for multigravida; provided that the fetal heart trace on CTG is normal).
- 4.9.3 Management of the third stage of labor:
  - 4.9.3.1 Active management is recommended by giving 10 units oxytocin in 1L Normal Saline, Methergin 0.1 mg intramuscular) with the delivery of anterior shoulder particularly in the following condition: Grand multiparous patients, previous history of post-partum hemorrhage, suspected big size fetus. Polyhydramnios.
  - 4.9.3.2 Delivery of the placenta should be done by the midwife/ physician who conducted the delivery by controlled cord traction after seeing the signs of separation.
  - 4.9.3.3 The placenta and membranes must be examined by midwife/ physician.
  - 4.9.3.4 The midwife should call the resident to examine the patient if there is delay in the delivery of placenta for more than 30 minutes and/or if excessive bleeding is seen

4.10 Episiotomy: See P&P of Episiotomy.

4.11 Transfer of Mothers from delivery room to postpartum area.

- 4.11.1 For uncomplicated deliveries, mothers and their babies may be transferred to postpartum area by their assigned midwives 15-30 minutes after delivery.
- 4.11.2 Vital signs should be taken hourly, uterine contractility and amount of lochia should be observed while in post-partum area at L&D and status should be documented.
- 4.11.3 Postpartum patients should not be transferred out of L&D before voiding.
- 4.11.4 Postpartum patients should be reviewed by resident 2 hours after delivery if labor was not complicated.
- 4.11.5 Postpartum orders must be written by residents physician for all patients before their transfer.
- 4.11.6 Following uncomplicated deliveries, patients are routinely transferred to ward by Staff Nurse.

## 5. MATERIAL AND EQUIPMENT:

5.1 CTG

## 6. RESPONSIBILITIES:

- 6.1 Physician
- 6.2 Nurse
- 6.3 Midwife

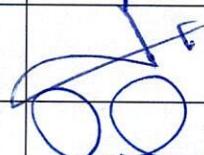
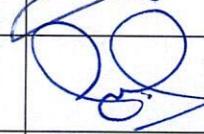
## 7. APPENDICES:

- 7.1 History of examination form
- 7.2 Partogram

## 8. REFERENCES:

- 8.1 Guidelines for Obstetrics and Gynecology/ Ministry of Health, General Directorate of Health Centers-Riyadh, 2013.
- 8.2 <http://www.dremeilkamel.com.au/patient-resources/obstetrics/cardiotocography/>.
- 8.3 <https://en.wikipedia.org/wiki/Partogram>.

## 9. APPROVALS:

	Name	Title	Signature	Date
Prepared by:	Ms. Hema Robi	Nurse Specialist		January 08, 2025
Prepared by:	Dr. Abdalla Mohamed Albasha	Obstetrician and Gynecologist		January 08, 2025
Reviewed by:	Dr. Mohannad Yaghmour	HOD – OBS &Gynecology		January 12, 2025
Reviewed by:	Mr. Sabah Turayhib Al - Harbi	Director of Nursing		January 13, 2025
Reviewed by:	Dr. Thamer Naguib	Medical Director		January 14, 2025
Reviewed by:	Mr. Abdulelah Ayed Al - Mutairi	QM&PS Director		January 15, 2025
Approved by:	Mr. Fahad Hezam Al - Shammari	Hospital Director		January 22, 2025

<b>KINGDOM OF SAUDI ARABIA</b>  <b>وزارة الصحة</b> Ministry of Health		رقم الملف الطبي: _____ الاسم: _____ الجنسية: _____ العمر: _____ سنة <input type="checkbox"/> Years     شهر <input type="checkbox"/> Months     يوم <input type="checkbox"/> Days	
Hospital: _____ Region: _____ Dept./Unit: _____		Name: _____ Nationality: _____ Age: _____	
		Date of Birth: _____ / _____ / 14     H _____ / _____ / 20 Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	

### LABOR AND DELIVERY NURSING INITIAL ADMISSION ASSESSMENT FORM

I. ADMISSION DATE: (dd/mm/yy) _____ / _____ / _____		TIME: _____										
II. ADMISSION DIAGNOSIS: _____												
III. ADMISSION SOURCE: _____		MODE OF ARRIVAL: _____										
<input type="checkbox"/> ER <input type="checkbox"/> OPD/ Clinic <input type="checkbox"/> others _____		<input type="checkbox"/> Walking <input type="checkbox"/> Wheelchair <input type="checkbox"/> Day care <input type="checkbox"/> Stretcher / Bed <input type="checkbox"/> Others										
INFORMATION SOURCE: <input type="checkbox"/> Patient <input type="checkbox"/> Family <input type="checkbox"/> Old Records <input type="checkbox"/> Not Available												
IV. ALLERGIES: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes , include medication , food and food products _____												
V. DATE & TIME:												
Onset of: <input type="checkbox"/> Labor <input type="checkbox"/> ROM <input type="checkbox"/> Bleeding Booked: <input type="checkbox"/> Yes <input type="checkbox"/> No - If no , give reason: _____												
Details	Name of Clinic Hb   Bld. Grp.	Gest. Age at first Booking RPR/VDRL	No. of visits HIV									
Problems at ANC _____												
VI. VITAL SIGNS:												
Temperature: _____		Respiratory Rate: _____	Weight: _____									
Pulse: _____		BP: _____	Height: _____									
VII. LEVEL OF CONCIOUSNESS: <input type="checkbox"/> Alert <input type="checkbox"/> Stuporous <input type="checkbox"/> Lethargic <input type="checkbox"/> Coma												
VIII. POSITION: <input type="checkbox"/> Prone <input type="checkbox"/> Supine <input type="checkbox"/> Fowler's <input type="checkbox"/> Semi-fowler's <input type="checkbox"/> Others: _____												
IX. RESPIRATORY STATUS: (AIRWAY)												
- Maintains own <input type="checkbox"/> Mechanical Ventilator <input type="checkbox"/> SIMV <input type="checkbox"/> Spontaneous <input type="checkbox"/> CMV FiO2 _____ O2 _____ RR _____ PEEP _____ TV _____		<input type="checkbox"/> ETT size _____ <input type="checkbox"/> TT size _____ <input type="checkbox"/> Oral airway size _____ <input type="checkbox"/> Nasal airway size _____ <input type="checkbox"/> Oxygen at _____ LPM <input type="checkbox"/> Mask <input type="checkbox"/> Nasal cannula										
X. ABDOMINAL EXAMINATION:												
Gestational Age	By dates	Palpation	SFH		Sonar							
Lie				Level of head (in fifths)								
Presentation				Attitude								
Liquor volume	Normal	Scanty	Polyhydramnios	EFW								
Contractions	Yes	No	Unsure	Less than 20 sec	20-40 sec	Greater than 40 sec	FH	Normal	Abnormal	Absent		
Type of FH abnormality												
XI. VAGINAL EXAMINATION:												
Speculum	Liquor	Thick	Thin	Blood			Cervix					
Digital Exam	Cervix	Effacement	Not felt			Application	Good	Poor				
Cervical Dilatation		Position										
Presentation					Moulding	OP	0	+	++	+++		
Station	-3	-2	-1	0	+1	2	3	PP	0	+	++	+++
Attitude	Well Flexed		Deflexed			Caput		Present	Not present			
Liquor	Clear	MSL	Grade	I	II	III	Blood Stain	Offensive				
Pelvic assessment	Adequate			Doubtful			Inadequate					

Name: _____	الاسم: _____	MRN: _____	رقم الملف الطبي: _____
<b>I. STAGE OF LABOR:</b>			
<input type="checkbox"/> Stage 1		<input type="checkbox"/> Stage 2	
<input type="checkbox"/> Stage 3		<input type="checkbox"/> Stage 4	
<b>RISK FACTORS</b>			
<input type="checkbox"/> Maternal		<input type="checkbox"/> Fetal	
<input type="checkbox"/> Labor			
<b>Definitions:</b> ROM: Rupture of Membranes RPR: Rapid Plasma Reagent VDRL: Venereal disease research laboratory CVS: Cardiovascular system MSL: Meconium stained liquor OP: Occipito- posterior SFH: Symphysio-fundal height HIV: Human Immunodeficiency virus PP: Parieto-parietal FH: Fetal Heart EFW: Estimated fetal weight			
<b>II. BREATHING:</b>			
a. Rhythm	b. Depth	c. Quality	d. Cough
<input type="checkbox"/> Regular	<input type="checkbox"/> Normal	<input type="checkbox"/> Normal	<input type="checkbox"/> None
<input type="checkbox"/> Irregular	<input type="checkbox"/> Shallow	<input type="checkbox"/> Labored	<input type="checkbox"/> Productive
<input type="checkbox"/> Paradoxical	<input type="checkbox"/> Deep	<input type="checkbox"/> Stridor	<input type="checkbox"/> Non-productive
		<input type="checkbox"/> Crackles	<input type="checkbox"/> Rhonchi
<b>III. CIRCULATION:</b>			
a. Pulse	b. Skin	c. IV Fluids _____	
<input type="checkbox"/> Regular	<input type="checkbox"/> Normal	<input type="checkbox"/> Pale	<input type="checkbox"/> Flushed
<input type="checkbox"/> Normal	<input type="checkbox"/> Warm	<input type="checkbox"/> Cyanotic	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Bounding	<input type="checkbox"/> Mottled	<input type="checkbox"/> Cool	<input type="checkbox"/> Dry
	<input type="checkbox"/> Diaphoretic	<input type="checkbox"/> Oedema	
		at _____ ml. level	..... drops
		per minute	
		IV Fluids _____	at _____
		cc. level	..... drops per minute
<b>IV. NUTRITION:</b>			
Diet:	Alternative route:	Nutritional Screening:	
<input type="checkbox"/> Regular	<input type="checkbox"/> NGT (size) _____	(Refer to dietitian if any of the below apply)	
<input type="checkbox"/> Special	<input type="checkbox"/> GT (size) _____	<input type="checkbox"/> Malabsorption	
<input type="checkbox"/> Fluid restriction	<input type="checkbox"/> TPN _____	<input type="checkbox"/> Diabetes	
Amount: _____		<input type="checkbox"/> Renal disease	
<b>Appetite:</b>	<b>Difficulties:</b>	<input type="checkbox"/> Liver disease	
<input type="checkbox"/> Good	<input type="checkbox"/> Swallowing	<input type="checkbox"/> BMI less than 19 or greater than 40	
<input type="checkbox"/> Fair	<input type="checkbox"/> Nausea	<input type="checkbox"/> Unable to take oral feeds	
<input type="checkbox"/> Poor	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Others: _____	
Comment: _____	<input type="checkbox"/> Indigestion	Referred:	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>V. ELIMINATION:</b>			
a. Bowel movement	b. Urine		
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal		
<input type="checkbox"/> Constipation	<input type="checkbox"/> Amber		
<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Cloudy		
	<input type="checkbox"/> Polyuria		
	<input type="checkbox"/> Oliguria		
	<input type="checkbox"/> Hematuria		
	<input type="checkbox"/> Foley catheter Fr _____		
<b>VI. OTHERS:</b> (Gastric tubes, dressing, restraint (cuff), pressure sore) _____			
<b>XVIII. ADOLESCENT ASSESSMENT (13-17 years old) - Not Applicable</b>			
Smoking: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how many cigarettes each day? _____			
Alcohol: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, how often? _____ /week			
Use of "street drugs" such as marijuana, ecstasy and others? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which ones? _____			
Psychosexual problems: <input type="checkbox"/> Yes <input type="checkbox"/> No Others: _____			
NOTE: Please fill-up the data required completely and legibly. Put check (/) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page.			
RN Initial/Date/Time: _____			

Name: \_\_\_\_\_ الاسم: \_\_\_\_\_ MRN: \_\_\_\_\_ رقم الملف الطبي: \_\_\_\_\_

**XIX. MEDICATIONS BROUGHT FROM HOME: (Include Homeopathic Remedies)  No  Yes**

Medication	Dose	Route	Frequency	Last Dose	If unable to take, why?

**XX. LOCATION OF MEDICATION:**

None  Given to Pharmacy  Given to family  Given to patient care area

**XXI. FUNCTIONAL SCREENING:**

If patient needs assistance with any of the following refer to rehabilitation Date: \_\_\_\_\_

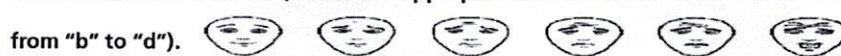
Physical therapy	<input type="checkbox"/> Mobility in bed	<input type="checkbox"/> Transfers	<input type="checkbox"/> Walking
Occupational therapy	<input type="checkbox"/> Eating	<input type="checkbox"/> Toileting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Speech therapy	<input type="checkbox"/> Washing	<input type="checkbox"/> Dressing	<input type="checkbox"/> Transfers
	<input type="checkbox"/> Swallowing		

**XXII. PAIN ASSESSMENT SCALE:**

**A) NUMERICAL RATING SCALE: Pain Score 0-10 (0-no pain), (5- moderate pain), (10-worst possible pain)**

**PAIN SCORE:** \_\_\_\_\_

**B) WONG BAKER PAIN SCALE: (Please tick appropriate answer from "a" and "e" and fill up the questions ask from "b" to "d").**



Intensity: 0 2 4 6 8 10

0 No pain  1-2 Mild pain, Annoying  3-4 Nagging pain, Uncomfortable  5-6 Miserable  
 7-8 Intense, Dreadful, Horrible  9-10 Worst pain, Possible

**C) BEHAVIORAL PAIN SCALE (To assess pain in ventilated, unconscious and/or sedated patients, please write appropriate answer and sum up).**

CATEGORY	DESCRIPTION	SCORE	Patient's Score
FACIAL EXPRESSION	Relaxed	1	
	Partially tightened (e.g. brow lowering)	2	
	Fully tightened (e.g. eyelid closing)	3	
	Grimacing	4	
UPPER LIMBS	No movement	1	
	Partially bent	2	
	Fully bent, with finger flexion	3	
	Permanently retracted	4	
COMPLIANCE WITH VENTILATION	Tolerating movement	1	
	Coughing with movement	2	
	Fighting with ventilator	3	
	Unable to control ventilation	4	
	<b>PATIENT'S TOTAL PAIN SCORE</b>		

Scoring: - 0-3 No pain - 4-6 Mild pain - 7-9 Moderate pain - 10-12 Severe pain

**a.) Location:** Where does it hurt? **b.) Onset:** When did the pain start?

**c.) Duration:** How long have you had this pain?

**d.) Quality:**  Constant, on and off  Radiating  Dull or sharp  Burning or pressure

**XXIII. "BRADEN SCALE" SKIN RISK ASSESSMENT**

(Write the appropriate answer and sum up from "a" to "f" to get the total score)

Category	Parameters	Score	Patients Score
a) Sensory perception	No impairment	4	
	Lightly limited	3	
	Very limited	2	
	Completely limited	1	
b) Moisture	Rarely moist	4	
	Occasionally moist	3	
	Very moist	2	
	Constantly moist	1	
c) Activity	Walks frequently	4	
	Walks occasionally	3	
	Chair Bound	2	
	Bedfast	1	

Name: _____	الاسم: _____	MRN: _____	رقم الملف الطبي: _____
d) Mobility		No limitations	4
		Slightly limited	3
		Very limited	2
		Completely immobile	1
e) Nutrition		Excellent	4
		Adequate	3
		Probably inadequate	2
		Very poor	1
f) Shear & Friction		No apparent problem	4
		Potential problem	3
		Problem	2
		Significant problem	1
<b>"BRADEN SCALE" TOTAL PATIENT'S SKIN RISK ASSESSMENT SCORE</b>			
Score of less than 16, patient is "at risk" for the development of pressure sores.			
<b>XXIV. "MORSE" FALLS RISK ASSESSMENT</b> (Write appropriate answer and sum up from "a" to "f" to get the total score)			
Category		Parameters	Score
a) History of falling (immediate & in not less than three (3) month time)		No	0
		Yes	25
b) Secondary diagnosis (include meds risk) diuretics; benzodiazepines antihypertensives; corticosteroids; drugs treating diabetes mellitus; polypharmacy (4 or more drugs)		No	0
		Yes	15
c) Ambulatory aids		None/ Bed rest/ Nurse assist	0
		Crutches/ stick/frame	15
		Furniture/walls	30
d) Intravenous therapy		No	0
		Yes	20
e) Gait		Normal/ Bed rest/ Wheelchair	0
		Weak	10
		Impaired	20
f.) Mental status		Oriented to own ability	0
		Over estimates/ forget limitations	15
<b>"MORSE" FALLS TOTAL PATIENT'S RISK ASSESSMENT SCORE</b>			
SCORING: 0-25 ( Low risk)		30-55 ( Medium risk)	>55 ( High risk)
<b>XXV. PSYCHOSOCIAL</b>			
Unusual concerns about patient's physical/social status: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Physician notified ..... (Date/Time).....			
<b>XXVI. SOCIAL STATUS</b>			
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Lives alone <input type="checkbox"/> Lives with family <input type="checkbox"/> Lives with friends			
<b>XXVII. ORIENTATION TO UNIT / ENVIRONMENT</b>			
<input type="checkbox"/> Toilets <input type="checkbox"/> Patient handbook <input type="checkbox"/> Bed control / rails	<input type="checkbox"/> Phone <input type="checkbox"/> Visiting Time <input type="checkbox"/> Call Bell	<input type="checkbox"/> ID Band <input type="checkbox"/> Patient's rights/responsibilities <input type="checkbox"/> Safety Measures	<input type="checkbox"/> Visitors policy <input type="checkbox"/> Smoking policy
<b>XXVIII. EDUCATIONAL/GENERAL NEEDS</b>			
Repeated, unscheduled admissions		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Newly diagnosed chronic/terminal illness		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family education needed for in-home care		<input type="checkbox"/> Yes	<input type="checkbox"/> No
NOTE: Please fill-up the data required completely and legibly. Put check (✓) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page.			
RN Initial/Date/Time: _____			

Name: _____	الاسم: _____	MRN: _____	رقم الملف الطبي: _____
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**XXIX. PHYSICAL DEFICITS (Please write appropriate information in example.)**

Cardiovascular: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....	Musculoskeletal/Mobility: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....
Respiratory: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....	Skin/Wound: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....
Neurological: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....	Cognitive/Mental: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....
Sensory/Speech: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....	Endocrine: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....
Gastrointestinal/Nutritional: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....	Language Barrier: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....
Genitourinary: <input type="checkbox"/> Yes <input type="checkbox"/> No example.....	Other Concerns:.....

**XXX. DISCHARGE PLANNING**

**SOCIOECONOMIC NEEDS:**

Lack of needed caregiver; family support	<input type="checkbox"/> Yes	<input type="checkbox"/> No
At risk of abuse or neglect	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inadequate resources: insurance, financial	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Foster parent, guardian etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inadequate or inappropriate post hospital plans	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**ENVIRONMENTAL NEEDS:**

Change in living arrangements	<input type="checkbox"/> Yes	<input type="checkbox"/> No
In-home care or equipment	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vocational and/or role loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inability to complete ADL	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**PSYCHOLOGICAL NEEDS:**

Potential of harm to self or others	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Suspected drug or alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Inappropriate patient/family behaviors	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficult adjustment to diagnosis (acceptance or diagnosis)	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**REFERRAL INDICATED:**  Yes  No

Referral sent to:  Social Services  Home Care  Other.....

High risk indicated but no referral sent, why?.....

**NOTE: Please fill-up the data required completely and legibly. Put check (.) if applicable. Use military time on your documentation. Affix your initial, date and time at the bottom of each page. Draw a line across empty spaces.**

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Name: _____	الاسم: _____	MRN: _____	رقم الملف الطبي: _____
<b>PARTOGRAM</b>			
Date & time of admission:	Consultant:		
E.D.D:	Parity:		
Special instructions:	0	1	2
	3	4	5
	6	7	8
	9	10	11
	12	13	14
	15	16	17
	18	19	20
	21	22	23
	24		
<b>FETAL HEART RATE</b>	190	180	170
	160	150	140
	130	120	110
	100	90	80
	70	60	
Duration of rupture of membranes (Hrs)	10	9	8
Liquor Moulding			
C			
E	D		
R	E		
V	S		
I	C		
X	E		
N			
T			
Duration of labor	0	1	2
	3	4	5
	6	7	8
	9	10	11
	12	13	14
	15	16	17
	18	19	20
	21	22	23
	24		

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OXYTOIN	0	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
DROPS/ MINUTE																								
	5																							
Contractions 4																								
Per 3																								
Minutes 2																								
1																								
Drugs And I.V. Fluids																								
Blood	200	190	180	170	160	150	140	130	120	110	100	90	80	70	60									
Pressure																								
and I.V. Fluids																								
Urine	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23
PROTEIN																								
ACETONE																								
GLUCOSE																								
TEMPERATURE	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23

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