HEALTH HOLDING
HAFER ALBATIN HEALTH CLUSTER
MATERNITY AND CHILDREN HOSPITAL

Department:	Obstetrics and Gynecology (L&D)		
Document:	Departmental Policy and Procedure		
Title:	Maternal Assessment and Re-Assessment		
Applies To:	All Obstetrics and Gynecology Staff		
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1. PURPOSE:

1.1 To summarize intrapartal physical, psychosocial and cultural assessment necessary for option maternal – fetal outcome.
1.2 To define the outer limits of normal progress of each phases and stage of labor.
1.3 To describe the procedure for performing Leopold's Maneuver and the information that can be obtained.
1.4 Maternal assessment is to assess:
1.4.1 Fetal activity can be used as a screening tool to provide information about fetal wellbeing:
1.4.1.1 Fetal tachycardia and bradycardia.
1.4.1.2 Evaluation of abnormal findings in a fetal heart tracing.
1.4.1.3 Identify non reassuring fetal heart pattern.

2. DEFINITIONS:

2.1 **Assessment**- is the systematic collection and review of patient data. All assessment data form is utilized by the multi-disciplinary team to determine and prioritize the care/needs of the patient. The determination and prioritization of care is based upon the diverse and unique needs of the patient, including biophysiologic, cognitive, behavioral, psychological, spiritual and social/cultural data and past medical history (Problem List). Additionally, assessmentdata identifies facilitating factors that pose potential barriers to the patient reaching theirgoals.
2.2 **Reassessment**- across disciplines is ongoing and occurs at designated intervalsduring the patient's treatment to determine the response to and effectiveness of thecare and interventions.

3. POLICY:

3.1 Labor and delivery form should be filled up completely with 4 names for the Saudi and complete name for the Non – Saudi, medical record number, sex, age, nationality, date of admission, time, physician.
3.2 Resident on duty should be notified upon admission of the patient to labor area by the assigned nurse/ midwife.
3.3 Obstetric and medical history should be obtained.
3.3.1 History includes the following information:
3.3.1.1 Patient name, Age.
3.3.1.2 Pregnancy Data.
3.3.1.2.1 Gravida, Para, last menstrual period, expected date of delivery.
3.3.1.3 Blood type, Rh factor, result of serology testing.
3.3.1.4 Allergies on medication, foods or other substance.
3.3.1.5 Medication during pregnancy.
3.3.1.6 Past and present medical history such as hypertension, diabetes and so forth.
3.3.1.7 Problems in the prenatal period such as blood pressure, bleeding, recurrent urinary tract infection and other infection.
3.3.1.8 Vital sign should be taken (blood pressure, temperature, pulse, respiration).

3.3.1.9 Laboratory result CBC, Hb ABO Rh, urine for analysis. HBSAg, HCV ab, HIV I & II Ag.
3.3.1.10 Fetal heart should be recorded continuously.
3.3.1.11 To complete the labor summary.

4. PROCEDURE:

4.1 Assessment

4.1.1 Assigned consultant or his/ her designee conduct initial assessment and document it in the patient's medical record immediately after admission. It includes (but is not limited to):

4.1.1.1 History of:

4.1.1.1.1 Chief complaint, details of present illness, obstetric gynecological, past medical and surgical history including previous admissions, relevant past social and family history, drug history and any prior adverse drug reactions and current medications (dose, route and frequency), allergies, pregnancy assessment

4.1.1.2 Complete physical examination considering age, sex and presenting problem e.g. pregnancy, adolescence, neonates, children

4.1.1.3 Assess the need for additional consultations e.g. cardiac, surgical or medical.

4.1.1.4 Order needed laboratory and imaging tests as indicated by patient condition

4.1.1.5 Communicate the information with the nursing and other healthcare consulted professionals and analyse the data obtained to identify the patient's healthcare needs, make a provisional diagnosis and decide the plan of care

4.1.1.6 Selects measurable realistic time based goals.

4.1.1.7 Document the plan of care on the 'Multidisciplinary plan of care form' and the planned orders on the physician order sheet.

4.1.2 Assess the patient's needs at admission and initiate discharge planning as needed

4.1.3 Assess and document the needed education for patient and family.

4.1.4 The initial assessment of patients admitted for surgery or invasive procedures will be recorded prior to surgery and will include in addition to the above:

4.1.4.1 The patient's pre-operative diagnosis, the results of relevant investigations and the pre-anesthetic assessment and discharge needs.

4.1.4.2 Pre-induction assessment occurs immediately prior to the induction of anesthesia and focuses on physiological stability and readiness of the patient for anesthesia.

4.1.4.3 The anesthetist documents the 'pre-anesthesia/ sedation assessment form'

4.1.4.4 The anaesthetists reassess the patient post operatively, on admission to the recovery room, during the patient's discharge from the recovery room.

4.1.4.5 The receiving unit physician and nurse reassess the patient upon arrival from the operating theatre to the unit.

4.1.5 Initial assessment in emergency room is based on patient's needs and condition; analysis of the reason for visit, objective findings from a targeted physical examination and conclude with a treatment plan.

4.1.6 For assessments done by a consultant in an outpatient visits more than 7 days before admission, the findings are reviewed and decision about its verification is made at admission by assigned physicians

4.1.7 If the medical assessment is greater than 7 days old at the time of admission or prior to an outpatient procedure, the medical history must be updated and the physical examination repeated

4.2 Physician Reassessment

4.2.1 Reassessment will be completed regularly:

4.2.1.1 At least once a day including weekends and holidays by a member of the assigned medical staff and documented in the medical records.

4.2.1.2 In intensive care units, it is additionally done upon the change of each shift.

4.2.2 In addition, reassessment will be performed:

4.2.2.1 Whenever there is a change in the patient's condition or diagnosis

4.2.2.2 To document medication/ procedure response, complications or side effects, compliance with treatment, need for continued treatment or discharge

4.2.2.3 Pre and post-operative

4.2.2.4 Upon transfer from one service or level of care to another. ICU physician conducts patient

assessment before transferring the patient. Both the intensive care and receiving physicians sign the 'ICU physician transfer/ Discharge form'

Reassessment of patient may result in changes in the plan of care

Document reassessment on designated form as needed on the multidisciplinary progress notes.

4.3 Nursing staff :

4.3.1 Initial assessment:

4.3.1.1 Vital signs: pulse, blood pressure, temperature, respiration, vaginal bleeding, fetal heart rate and CTG for pregnant ladies is conducted on arrival, followed by a full assessment that must be completed within 24 hours of, CTG for admission and documented on designated forms.

4.3.1.2 The assessment will include the following:

4.3.1.2.1 Physical status: head to toe examination and documentation on designated forms

4.3.1.2.2 Pain :

4.3.1.2.2.1 All patients are screened for pain on admission, in the emergency room and in the outpatient clinics.

4.3.1.2.2.2 If pain is detected, conduct pain assessment and inform physician. Provide pharmacologic and non-pharmacologic management.

4.3.1.2.2.3 Do reassessment using the appropriate pain scale and with accordance with age and condition of the patient.

4.3.2 Nursing Reassessment

4.3.2.1 All patients will have focused reassessment at regular intervals depending on their level of care, their needs as determined by both physician's order and the nurse's professional judgement. It minimally includes vital signs and a focus review in keeping with the specific patient's condition.

4.3.2.1.1 In addition, patients will be reassessed:

4.3.1.1.1.1 At change of shift: reassessment will be completed by the assigned nurses at the time of outgoing to the incoming nursing staff, the content of which is defined and documented on the nursing reassessment form, maternal nursing daily reassessment form

4.3.1.1.1.2 Pre and post operatively: document vital signs, focused assessment and fill the 'pre-operative checklist form'.

4.3.2.1.1.3 On transfer to another level of care or diagnostic/ procedure area by the transferring and receiving nurses. Document on the 'ICU nurses internal/ discharge form' and on nurse's progress note.

4.3.2.1.1.4 When there is a change in functional abilities, treatment, diagnosis, deterioration or improvement in condition or after a fall.

4.3.2.1.1.5 Women in labor will be assessed and reassessed according to obstetric department policy: Management of patient progress at labor and delivery.

4.3.2.2 Reassessment of pain:

4.3.2.2.1 Screening for pain is done every 2 hours for intensive care patients, every 4 hours for intermediate care and every 8 hours shift for other patients

4.3.2.2.2 If pain is detected, it is assessed and managed according to its severity

4.3.2.2.3 Reassessment is done after 30 minutes of parenteral medication, 60 minutes of oral medications or non-pharmacologic interventions.

4.3.2.2.4 Reassessment is continued until pain resolves

4.4 Discharge planning:

4.4.1 Initial assessment: involved healthcare professionals will determine the need for discharge planning as part of the initial assessment to ensure safe transition of hospitalized patients to home care e.g. the following cases, but not limited to:

4.4.1.2 Patients with continuing medical, nursing and education needs e.g. preterm infants, patients with colostomy, inborn errors of metabolism, to be discharged on tube feeding, need physiotherapy or social services etc.

4.4.1.3 Patients who require multidisciplinary services or home healthcare services at the time of discharge

4.4.1.4 Patients with chronic respiratory problems in need for respiratory assisting equipment or suctioning at home.

4.4.1.5 Other patients as decided by attending consultant or members of the involved healthcare professionals.

4.4.2 Reassessment of the patient's discharge needs and required equipment or supplies is an ongoing process performed by the multidisciplinary team throughout the patient's stay and includes information gathered from patient medical record review, the health care team and the patient and family. It is done at least weekly or sooner as indicated by the patient's condition.

4.4.3 The patient/ family will be involved in the discharge planning process as appropriate.

4.4.4 Involved healthcare worker documents the section of the form relevant to his/ her scope of work.

5. MATERIALS AND EQUIPMENT:

5.1 Vital signs monitor
5.2 Stethoscopes
5.3 Sonic aid
5.4 CTG Machine
5.5 Weight scales
5.6 Measuring length and height equipment
5.7 Various assessment and reassessment forms

6. RESPONSIBILITIES:

6.1 Physician
6.2 Nurse
6.3 Midwives

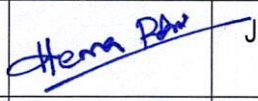
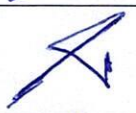
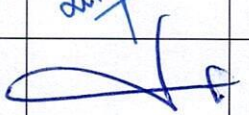
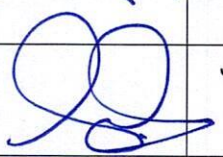
7. APPENDICES:

7.1 Maternal Assessment Form

8. REFERENCES:

8.1 Ministry of Health, General Nursing Administration, Functions and Duties Policies and Procedure

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 12, 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

KINGDOM OF SAUDI ARABIA

وزارة الصحة
Ministry of Health

Hospital: _____ :مستشفى

Region: _____ :المنطقة/المحافظة

Dept./Unit: _____ :القسم/الوحدة

MRN: | | | | | | | | | | | :رقم الملف الطبي

Name: _____ :الاسم

Nationality: _____ :الجنسية

Age: _____ ☐ سنة Years ☐ شهر Months ☐ يوم Days :العمر

Date of Birth: ____/____/14____ H ____/____/20____ :تاريخ الميلاد

Gender: ☐ Male ☐ Female :الجنس

OBSTETRIC HISTORY AND ASSESSMENT FORM

Booking Date: ____/____/____ Telephone No.:

Consultant: Referred By:

LMP: / / E.D.D.: / /

MENSTRUAL CYCLE: / REGULAR: ☐ YES ☐ NO PILL WITHDRAWAL: ☐ YES ☐ NO

GRAVIDA PARA +

YEAR	DURATION of PREGNANCY	MODE OF DELIVERY	LIVE, SB ABORTION	SEX	WEIGHT	COMPLICATIONS (GDM,PET,APH,PPH,etc.)	METHOD OF FEEDING
						GDM ☐	☐ Breastfeeding
						APH ☐	☐ Bottlefed
						BPH ☐	
						BLADDER INF. ☐	
						OTHERS: ☐ SPECIFY:	

MEDICAL HISTORY:

Give details of relevant diseases

☐ Diabetes ☐ YES ☐ NO IF Yes, Treatment: ☐ Oral ☐ Insulin; dose: _____

☐ Hypertension ☐ YES ☐ NO IF Yes, Treatment: _____

☐ Cardiac Disease _____

☐ Pulmonary Disease _____

☐ Renal Disease _____

☐ Blood Disease _____

☐ Infertility _____

☐ Others _____

SURGICAL HISTORY:

ALLERGIES: ☐ YES ☐ NO IF Yes, Specify; _____

MEDICATION HISTORY:

BLOOD TRANSFUSION: ☐ YES ☐ NO IF Yes, When? _____

FAMILY HISTORY:

☐ Diabetes ☐ Multiple pregnancy ☐ Others

☐ Hypertension ☐ Malformation

Name: _____ الاسم:	MRN: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] رقم الملف الطبي:

EXAMINATION:

Height: _____ cm. Weight: _____ kg.

Thyroid: ☐ Normal ☐ Abnormal **Specify:**	**Heart:** ☐ Normal ☐ Abnormal **Specify:**
Breast: ☐ Normal ☐ Abnormal **Specify:**	**Lungs:** ☐ Normal ☐ Abnormal **Specify:**
Veins: _____	**Abdomen:** _____

ANTENATAL INVESTIGATIONS:

Hgb: Date: / /	VDRL: ☐ Yes ☐ No IF Yes, Reaction: _____
ABO Group: ☐ A ☐ B ☐ AB ☐ O RHESUS: ☐ (-) ☐ (+)	Toxoplasmosis: ☐ Negative ☐ Positive ☐ Titer
Indirect Coombs Test(ICT): At Booking: At 32 weeks:	HBs Ag: ☐ Negative ☐ Positive
Blood Sugar: ☐ Normal ☐ Abnormal	Rubella: ☐ Immune ☐ Non-immune

OTHER INVESTIGATIONS:

ULTRASOUND FINDING:

Booking USS:

Follow-up USS:

RISK CARD:

Reproductive History	Medical History	Current Pregnancy
☐ Age > 35 yrs	☐ Cardiac Disease	☐ Multiple pregnancy
☐ Parity ≥ 6	☐ Chronic hypertension	☐ Placenta previa and/or APH
☐ Abortions ≥ 3	☐ IDDM	☐ Anemia < 8gm %
☐ PTL	☐ Chronic renal disease	☐ PET
☐ Baby ≥ 4.5 kg	☐ Pulmonary disease	☐ IUGR
☐ Baby ≤ 2.5 kg	☐ Sickle cell disease	☐ GDM
☐ SB or NND	☐ SLE	☐ Preterm PROM
☐ Eclampsia	☐ Thyroid disease	☐ Hydramious or oligohydramious
☐ Scared uterus	☐ Epilepsy	☐ Rh immunization
☐ PPH	☐ Thromboembolic disease	☐ Malpresentation at term

PHYSICIANS NAME : _____ SIGNATURE: _____

NURSE # 1: _____

NURSE # 2: _____