5 INTRAPARTUM CARE

5.2 ASSESSMENT OF THE WOMAN ON ADMISSION TO LABOUR AND BIRTH SUITE

5.2.1 ASSESSMENT OF THE WOMAN IN LABOUR

AIM

To inform and support decision making by midwives on the care of women in labour.

KEY POINTS

1. Labour and birth is considered to be a normal physiological process until established otherwise.¹
2. The midwife shall keep the woman informed of progress throughout labour.
3. The midwife, in collaboration with the woman, is responsible for decision making (in the absence of risk factors).¹
4. The woman and the midwife work together during labour and birth recognising the active role that both play in the woman’s care.¹
5. The time of admission to the birthing environment is a vulnerable time for women who may have expectations, fears and uncertainties related to labour and birth.²
6. The woman and her needs shall be the priority of the midwife.
7. The midwife shall approach the admission to the birth environment using a sensitive, woman centred approach to undertake the routine admission tasks as outlined below.
8. The current WNHS Policy for visitors to Labour and Birth Suite states a maximum of 2 visitors per patient. In hours this will be coordinated by the LBS staff. After hours, if more than 2 people wish to visit a woman in the Labour and Birth Suite, security must contact the Hospital Clinical Manager and obtain approval for the additional visitors prior to them entering the department.

PROCEDURE

1. Welcome the woman and her support person into the Labour and Birth Suite.
2. Ascertain whether the woman has a birth plan and refer to it for personal preferences.
3. Ensure the woman is wearing an identification band and check the details on it with her medical records and the woman.
4. Check in the woman's pregnancy record for
   - MRSA and VRE status
   - Hepatitis B status
   - Hepatitis C status
   - HIV status
   - Group B streptococcal status
   - Blood group and rhesus status
   - Haemoglobin
   - Recent ultrasound reports
   - Clarification of allergies
   - Risk factors
5. Assess maternal condition
   • Perform and document maternal vital signs – respiratory rate, oxygen saturation, heart rate, blood pressure, temperature and conscious state.
   • Perform a urinalysis and document the findings.
   • Assess the woman for
     ➢ skin integrity - see Clinical Guideline A.2.11 Pressure Injury Prevention and Management
     ➢ Risk of falls – see clinical Guideline A.2.12 Falls Risk Assessment and Management of Patient Falls

6. Obtain a medical, surgical and obstetric history and identify risk factors. See clinical guideline B 5.2.4 Moderate and High Risk Women admitted to MFAU and Labour and Birth Suite.

7. Perform and document an abdominal examination to assess presenting part and station, lie, position, fetal size and amniotic fluid volume.

8. Auscultate and document the fetal heart rate. Commence continuous electronic monitoring as appropriate. See clinical guideline B 5.6 Intrapartum Fetal Heart Rate Monitoring

9. Assess the frequency, duration and strength of any contractions.

10. Perform a vaginal examination. Note the following
    • The colour of the amniotic fluid if present.
    • Cervical dilatation and effacement.
    • Any caput or moulding present.
    • Level and position of presenting part.

11. Offer the woman the opportunity to shower and change if appropriate.

12. Notify the shift coordinator of the findings.

13. Notify the medical officer of the woman’s admission.

REFERENCES (STANDARDS)


National Standards – Standard 1 Clinical Practice
Legislation - Nil
Related Policies – B Section 5 Intrapartum Care
Other related documents – Nil

RESPONSIBILITY

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