اسم السياسة /الخطة: سياسة التقييم الأولي لجميع النساء في المخاض عند الدخول الى المستشفى Initial medical Evaluation in labor
رقم السياسة/ الخطة: OSD–PP– 14

المجموعة: رعاية المرضى	المعنيين بالسياسية: كوادر قسم النسائية والتوليد	
إعداد: قسم النسائية والتوليد	تاريخ الاعداد: 2025/8/12	توقيع مسؤول صالات الولادة:
دققت من قبل: مدير قسم الجودة	تاريخ التدقيق:2025/11/1	التوقيع:
اعتمد من قبل: مدير المستشفى	تاريخ الاعتماد:8/11/ 2025	التوقيع:
عدد صفحات السياسة/الخطة: (6)	الطبعة : الاولى	تاريخ المراجعة القادمة:8 / 11 /2027

1. Purpose:

1.1 An initial evaluation is performed to:

1.1.1 Evaluate the current health status of the mother and baby

1.1.2 Identify risk factors which could influence the course or management of labor

2. Policy:

2.1 Detailed History taking , Interview the patient as soon as she arrives.

2.2 Determine Risk Factors .

2.3 Physical examination . Vital signs , BMI

2.4 Contractions.

2.5 Fetal Heart Rate

2.6 Estimated Fetal weight .

2.7 Dilatation and Effacement

2.8 Fetal Orientation

2.9 Evaluation of the Maternal Pelvis

2.10 Status of Fetal Membranes

2.11 Investigations .

2.12 Proper Documentation.

2.13 Informing the On call Consultant , or the booked Physician during the patient **Antenatal** care. .

3. Scope:

3.1 This policy is applicable for all patients admitted to labor Ward .

4. Responsibility:

4.1 All Obstetric and Gynecology Residents Doctors are responsible to assure compliance with this policy.

5. Definitions:

5.1 None

6. Equipments/Forms/Attachments:

6.1 Ultrasound.

6.2 CTG

6.3 Gloves for vaginal examination

6.4 Admission notes for labor document.

7. Procedure:

7.1 Interview the patient:

7.1.1 Greet the woman with a smile and a personal welcome, establish her language needs, introduce yourself and explain your role in her care.

7.1.2 Maintain a calm and confident approach so that your demeanor reassures the woman that all is going well.

7.1.3 Knock and wait before entering the woman's room, respecting it as her personal space, and ask others to do the same.

7.1.4 Ask how the woman is feeling and whether there is anything in particular she is worried about.

7.1.5 Assess the woman's knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her

7.1.6 Assess the woman's knowledge of strategies for coping with pain and provide balanced information to find out which available approaches are acceptable to her.

7.1.7 Refusal of specific procedures must be recorded, timed, dated and signed in the woman's health record.

7.1.8 Patient must consent on refuse of procedure consent form as hospital policy

7.2 <u>History:</u>

7.2.1 Maintain eye contact.

7.2.2 **Introduce yourself** and confirm the name by which the woman wishes to be called.

7.2.3 Inform the woman that you need to ask several questions and that you will stop whenever a contraction begins.

7.2.4 Ask open-ended questions when possible. For example, "Can you tell me about any problems you have had during this pregnancy?" instead of "Have you had an infection (or problem) during this pregnancy?".

7.2.5 Detailed Obstetrical History must be taken

7.2.5.1 Gravidity and parity

7.2.5.2 Obstetric outcomes and complications in past deliveries **,** such as : antepartum hemorrhage , and postpartum hemorrhage)

7.2.5.3 Gestational Age (Last menstrual period , Estimated due date)

7.2.5.4 Gynecological History

7.2.5.5 Social and family history.

7.2.5.6 Allergies.

7.2.5.7 Medical history and Surgical History.

7.2.5.8 Review of Systems

7.2.5.9 Certain key questions will provide considerable insight into the patient's pregnancy and current status:

7.2.5.9.1 What brought you in to see me?

7.2.5.9.2 Are you contracting? When did they start?

7.2.5.9.3 Are you having any pain?

7.2.5.9.4 Are you leaking any fluid or blood? When did that begin?

7.2.5.9.5 Have there been any problems with your pregnancy?

7.2.5.9.6 Has the baby been moving normally?

7.2.5.9.7 When did you last eat? What did you have?

7.2.5.9.8 Are you allergic to any medication?

7.2.5.9.9 Do you normally take any medication?

7.2.5.9.10 Have you ever been hospitalized for any reason?

7.2.5.9.11 If malnutrition is suspected, a rapid assessment of the mother's nutritional status is essential. This includes reviewing her dietary intake, weight gain during pregnancy, and physical signs of malnutrition .and if

malnutrition is suspected then the detrition should be informed.

7.3 Risk factors Assessment

7.3.1 Confirm that that there is no identifiable Risk factors ,

7.3.2 Low Risk patient are:

7.3.2.1 $37–41^{6/7}$ weeks gestation

7.3.2.2 estimated fetal weight appropriate for gestational age

7.3.2.3 absence of meconium or bleeding

7.3.2.4 vertex presentation

7.3.2.5 absence of any medical or obstetrical complications.

7.4 Vital Signs:

7.4.1 Elevated BP suggests the presence of pre-eclampsia.

7.4.2 Elevated BP may be defined as a persistently greater than 140 systolic or 90 diastolic. Usually, if one is elevated, both are elevated.

7.4.3 Elevated temperature suggests the possible presence of infection.

7.4.4 Many pregnant women normally have oral temperatures of as much as 37.7.

7.4.5 These mild elevations can also be an early sign of infection.

7.4.6 While a pregnant pulse of up to 100 BPM or greater may be normal, rapid pulse may also indicate hypovolemia.

7.5 Contractions:

7.5.1 Check the frequency and duration of any uterine contractions.

7.5.2 In some cases, the patient will have been timing the contractions. Placing your hand on the maternal abdomen, you will be able to feel each contraction as the normally soft uterus becomes firm and rises out of the abdomen. Time the contractions from the beginning of one to the beginning of the next one. Also note the duration of the contractions and their relative intensity (mild, mild-to-moderate, moderate, severe).

7.5.3 Contractions can also be followed by use of an electronic fetal monitor. In this case, the paper channel will show the rhythmic peaks that correspond to a uterine contraction.

7.6 Fetal Heart Rate:

7.6.1 Record the fetal heart rate.

7.6.2 This can be done with a fetal Doppler device, and electronic fetal monitor, ultrasound visualization of the fetal heart

7.6.3 Normal rates are between 120 and 160 BPM at full term. Post term babies may sometimes normally have rates as low as 110 BPM.

7.6.4 The fetal heart rhythm should be regular, without any skipped beats or compensatory pauses

7.6.5 Auscultate the FHR for a minimum of 1 minute immediately after a contraction and record it as a single rate .

7.6.6 palpate the maternal pulse to differentiate between maternal heart rate and FHR .

7.6.7 perform CTG for at least 20 minutes .

7.7 Estimated Fetal Weight:

7.7.1 Estimate the fetal weight. An average baby at full term weighs 2.5 kg to 4 kg .

7.7.2 Using Ultrasound fetal biometry .

7.8 Cervical Dilatation and Effacement

7.8.1 Using sterile gloves and lubricant, perform a vaginal exam and determine the dilatation and effacement of the cervix. A small amount of bleeding during the days or hours leading up to the onset of labor is common and called bloody show.

7.8.2 Dilatation is expressed in centimeters :

7.8.2.1 1.5 cm: One finger fits tightly through the cervix and touches the fetal head.

7.8.2.2 2.0 cm: One finger fits loosely inside the cervix, but you can't fit two fingers in.

7.8.2.3 3.0 cm: Two fingers fit tightly inside the cervix.

7.8.2.4 4.0 cm: Two fingers fit loosely inside the cervix.

7.8.2.5 6.0 cm: There is still 2 cm of cervix still palpable on both sides of the cervix.

7.8.2.6 8.0 cm: There is only 1 cm of cervix still palpable on both sides of the cervix.

7.8.2.7 9.0 cm: Not even 1 cm of cervix is left laterally, or there is only an anterior lip of cervix.

7.8.2.8 10.0 cm: I can't feel any cervix anywhere around the fetal head.

7.8.3 Effacement is easiest to measure in terms of centimeters of thickness, ie., 1 cm thick, 1.5 cm thick, etc. Alternatively, you may express the thickness in percent of an uneffaced cervix...ie, 50%, 90%, etc. This expression presumes a good knowledge of what an uneffaced cervix should feel like.

7.9 Fetal Presentation:

7.9.1 By abdominal and pelvic examination , Ultrasound must be done first to exclude any contraindication for Vaginal examination as placenta previa .

7.9.2 There are basically 3 alternatives:

7.9.2.1 Cephalic (head first, or vertex)

7.9.2.2 Breech (butt or feet coming first)

7.9.2.3 Transverse lie (side-to-side orientation, with the fetal head on one side and the butt on the other)

7.9.3 Most of the time, the fetus will be head first (vertex).

7.9.4 The easiest way to determine this presentation is by pelvic exam. The fetal head is hard and bony, while the fetal butt is soft everywhere except right over the fetal pelvic bones.

7.9.5 When the baby is presenting butt first, the presenting part is very soft, but with hard areas within it (sacrum and ischial tuberosities).

7.9.6 If one or both feet are presenting first, you will feel them.

7.9.7 If you don't feel any presenting part (head or butt) on pelvic exam, there is a good chance the baby is in transverse lie (or oblique lie).

7.9.8 Transverse lie or oblique lie can be suspected if the fundal height measurement is less than expected and if on abdominal exam, the basic orientation of the fetus is side-to-side.

7.9.9 More experienced examiners can tell much from an abdominal exam.

7.9.10 Making a "V" with their thumb and index finger and pressing down just above the pubic bone, they can usually feel the hard fetal head at the pelvic inlet.

7.9.11 Ultrasound can be used to confirm the presenting part .

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7.9.14 When the baby is presenting butt first, the presenting part is very soft, but with hard areas within it (sacrum and ischial tuberosities).

7.9.15 If one or both feet are presenting first, you will feel them.

7.10 Evaluation of the Maternal Pelvis

7.10.1 This is frequently performed prenatally, but can also be done at the initial evaluation of a patient in labor.

7.11 Status of Fetal Membranes:

7.11.1 With a pelvic examination, determine the status of the fetal membranes (intact or ruptured).

7.11.2 A history of a sudden gush of fluid is suggestive, but not convincing evidence of ruptured membranes. Sudden, involuntary loss of urine is a common event in late pregnancy.

7.11.3 Usually, ruptured membranes are confirmed by a continuing, steady leakage of amniotic fluid, pooling of clear in the vagina on speculum exam.

7.12 Investigations:

7.12.1 Following admission, the hemoglobin or hematocrit, as routine .

7.12.2 Women with no prenatal care should, in addition, have a blood type, Rh factor, and atypical antibody screen performed.

7.12.3 Other tests may be indicated, based on individual history., regarding referred from outpatient clinic or direct emergency complaint , for all Cases .

7.13 After completing initial evaluation , the resident doctor cooperates with the booking consultant to decide the plan of care during labor according to results of initial evaluation which must include at least mode of delivery , pain management plan , the need for augmentation of labor using oxytocin , or the need for Induction of labor .

7.14 Proper monitoring and follow up of the mother and the fetus are conducted within periods corresponding to the stage of labor . (refer to policy first stage of labor) ……..

7.15 Management of high Risk comorbidities (GDM , Multiparity)

8. References:

8.1 NICE 2024