Document Title:	**COMPLETION OF THE PARTOGRAM IN PREGNANCY**		
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Related Trust Policies (to be read in conjunction with)	(Refer to the main body of the text) 04071 Standard Infection Prevention 04072 Hand Hygiene 04253 Nutrition in Labour and Antacid Prophylaxis for the Pregnant Woman at Term 04265 Guideline for fetal monitoring in pregnancy 04288 Administration of Syntocinon for Induction and Augmentation of Labour 09062 Mandatory training policy for Maternity Service incorporating training needs analysis 09079 Management of Normal Labour and Prolonged Labour in Low Risk Patients

Document Review History:			
Version No:	**Authored/Reviewer:**	**Summary of amendments/Superseded documents:**	**Issue Date:**
1.0	Julie Bishop		November 2005
2.0	Chris Berner		June 2012
3.0	Sarah Moon		November 2012
3.1	Sarah Moon	Clarification to point 4.4	January 2013
3.2	Gemma May	Clarification to points 4.0, 5.2, 7.3 and Appendix A	February 2014
4.0	Ros Bullen-Bell		16 November 2015
5.0	Louisa Windus	Changes to sections 5.0, 9.0 and 14.0, removal of Appendices	31st October 2018

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1.0 Purpose

1.1 To provide health care professionals with guidance regarding the completion of the partogram for all patients with the following:

- All patients who present in active labour, irrespective of place of delivery. The active phase of labour commences at or after 4cm of cervical dilatation.
- Commencement of a syntocinon infusion to induce or augment labour
- Threatened premature labour in conjunction with the use of Atosiban

1.2 This guideline includes women without co-existing morbidities (including previous uterine surgery or complications of previous deliveries which may impact upon this delivery).

2.0 Equality and Diversity

2.1 Mid Essex Hospital Services NHS Trust is committed to the provision of a service that is fair, accessible and meets the needs of all individuals.

3.0 Definition

3.1 The partogram is a pictorial assessment of the progress of normal labour; The WHO (World Health Organisation) concluded that the standard use of a cervicogram with standard definitions of labour and labour progress resulted in a reduction in the incidence of prolonged labour, the need for augmentation and the Caesarean section rate.

3.2 With the use of a partogram, the progress in labour can be seen at a glance on one sheet of paper, slow or obstructed labour can be recognised readily and described more easily.

4.0 Completion of the Partogram

4.1 The partogram should be commenced as stated in point 1.1 of this guideline. The four hourly ‘action and alert’ lines can be used to easily observe the progress of labour.

4.2 The time and date should be entered every 30 minutes using the 24 hour clock. The hour should be documented on the line of each square. Each hourly square should have 4 fetal heart recordings documented (every 15 minutes).

4.3 Fetal observations

4.3.1 Auscultation of the fetal heart rate should be recorded in the fetal heart rate section of the partogram and documented every 15 minutes. It is recorded on the graph by a dot • and each dot should be linked by a line.

4.3.2 During the second stage of labour the fetal heart is recorded every 5 minutes on page 38 of the labour care records. The recordings on the partogram are to continue every 15 minutes on the fetal heart rate section.
(Refer to ‘Guideline for fetal monitoring in pregnancy’; register number 04265)

4.4 **Maternal observations** should include a minimum of

- 4 hourly temperature, blood pressure, respirations and pulse rate documented within the MEOWS chart including the MEOWS score
- Additional hourly pulse rate
- Half hourly documentation of the frequency of contractions
- Aim to empty the bladder within every four hours and document urinalysis
- Vaginal examination should be offered four hourly
- Ensure adequate levels of hydration are maintained
- Assess need for analgesia continuously
- Amniotic fluid colour to be recorded hourly

4.5 **Liquor** - the presence or absence of liquor should be marked in the appropriate space, using letter symbols;

- I = Intact membranes
- C= Clear liquor
- M = Meconium stained liquor
- BS = Blood stained liquor
- A = An absence of liquor

4.6 **Moulding** of the fetal skull bones is an important indication of how adequately the pelvis can accommodate the fetal head. An increase in moulding with the fetal head high in the pelvis is an ominous sign of pelvic disproportion. Moulding should be marked on the partogram as;

0 = Separated bones, sutures felt easily

+ = Bones just touching each other

++ = Overlapping bones, reducible

+++ = Severely overlapping bones, non reducible

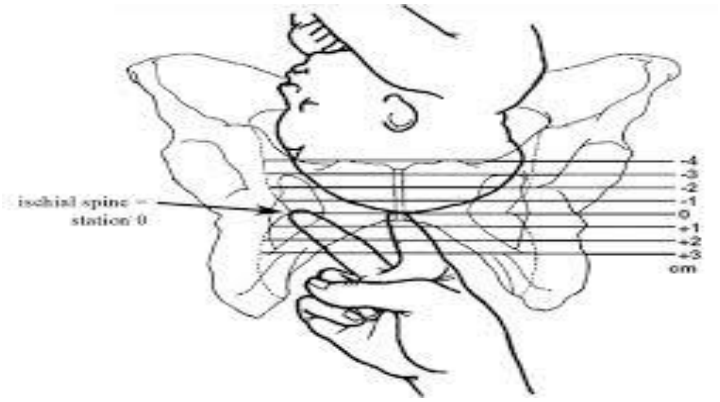
4.7 **Completing the Cervicograph** - The cervicograph is the section of the partogram which depicts cervical dilatation and descent of the presenting part in relation to time. Use of the cervicograph enables the progress of labour to be ascertained and delay in the progress readily recognised.

4.8 Within the cerviograph cervical dilatation and descent should be documented by plotting on the chart; cervical dilatation should be marked every four hours by an **X,** (or more frequently if assessments are more often) marking in the appropriate time space when the examination is performed. A line should then be drawn between the markings using a straight edged ruler.

4.9 Descent of the head is measured during the same vaginal examination. It is expressed in terms of descent of the fetal head in relation to the Ischial spines.

<u>It is recorded on the graph by a dot •</u>

This denotes the level of descent at each vaginal examination which will correspond to the cervical dilatation symbol. As the cervical dilatation increases and descent of the head occurs the plotted lines will meet.



5.0 The Alert and Action Lines

5.1 Parallel lines can be drawn on the partogram at the time of the first vaginal examination in active labour or prior to/following commencement of syntocinon.

5.2 The **alert** lines are the same for women in their first and subsequent labours – however, for second or subsequent labours a slowing in the progress of labour is also a cause for concern. We would anticipate the cervix of a nulliparous woman to dilate ½ cm an hour and for a parous woman to dilate ½-1cm per hour from 4cm dilated.
The **alert** is drawn from the point of cervical dilatation noted at the first vaginal examination, in increments of ½cm per hour.

5.3 If the plotted dilatation of the cervix moves to the right of the alert line this may denote a prolonged labour which then requires immediate action i.e. an amniotomy and vaginal reassessment 2 hours later. (Refer to the Guideline for the Management of Normal Labour and Prolonged Labour in Low Risk Patient 09079 and the Guideline for Administration of Oxytocin for Augmentation of Labour 04288).

5.4 The **action line** is a line parallel to the alert line which is plotted 4 hours to the right of the alert line. If the plotted dilatation of the cervix moves to the right of the alert line and crosses the action line (after amniotomy and review) this denotes a prolonged labour which requires immediate referral to the obstetric registrar on call for obstetric review and active management

5.5 **Drugs and fluids** should be recorded as indicated on the partogram.

5.6 The midwife should ensure that she initials the partogram hourly as indicated.

6.0 Contractions

6.1 Observe and record every 30 minutes the number of contractions palpated in the active phase.

6.2 Each square on the partogram measures one contraction.

6.3 Palpate and note the number of contractions made in 10 minutes and the duration of the contraction in seconds (time from when the first contraction is palpated until it phases away). The strength of the contractions is marked as weak, moderate or strong, by increasing the number of lines used to fill the boxes indicating the number of contractions in 10 minutes.

7.0 Documentation

7.1 Ensure that all recordings and findings are accurately and legibly recorded in the patient's handheld records and onto any formal charts, such as prescription chart, fluid balance chart.

7.2 The midwife should document the date and time of the commencement of the partogram.

7.3 On completion of the partogram, the midwife must complete the chart by recording the time, date, method of delivery and Apgar scores at the end of the partogram.

8.0 Staffing and Training

8.1 All staff receive regular updates regarding the recognition of the unwell woman and abnormal fetal wellbeing. (Refer to 'Mandatory training policy for Maternity Services incorporating training needs analysis'. Register number 09062)

8.2 All midwifery and obstetric staff must attend yearly mandatory training which includes skills and drills training.

8.3 All midwifery and obstetric staff are to ensure that their knowledge and skills are up-to-date in order to complete their portfolio for appraisal.

9.0 Professional Midwifery Advocates

9.1 Professional Midwifery Advocates provide a mechanism of support and guidance to women and midwives. Professional Midwifery Advocates are experienced practising midwives who have undertaken further education in order to supervise midwifery services and to advise and support midwives and women in their care choices.

10.0 Infection Prevention

10.1 All staff should follow Trust guidelines on infection prevention by ensuring that they effectively 'decontaminate their hands' before and after each procedure.

11.0 Audit and Monitoring

11.1 Audit of compliance with this guideline will be considered on an annual audit basis in accordance with the Clinical Audit Strategy and Policy (register number 08076), the Corporate Clinical Audit and Quality Improvement Project Plan and the Maternity annual audit work plan; to encompass national and local audit and clinical governance identifying key harm themes. The Women's and Children's Clinical Audit Group will identify a lead for the audit.

11.2 As a minimum the following specific requirements will be monitored:

- Documentation of observations in labour

- Process for audit, multi-disciplinary review of audit results and subsequent monitoring of action plans

11.3 A review of a suitable sample of health records of patients to include the minimum requirements as highlighted in point 11.2 will be audited. A minimum compliance 75% is required for each requirement. Where concerns are identified more frequent audit will be undertaken.

11.4 The findings of the audit will be reported to and approved by the Multi-disciplinary Risk Management Group (MRMG) and an action plan with named leads and timescales will be developed to address any identified deficiencies. Performance against the action plan will be monitored by this group at subsequent meetings.

11.4 The audit report will be reported to the monthly Directorate Governance Meeting (DGM) and significant concerns relating to compliance will be entered on the local Risk Assurance Framework.

11.5 Key findings and learning points from the audit will be submitted to the Clinical Governance Group within the integrated learning report.

11.6 Key findings and learning points will be disseminated to relevant staff.

12.0 Guideline Management

12.1 As an integral part of the knowledge, skills framework, staff are appraised annually to ensure competency in computer skills and the ability to access the current approved guidelines via the Trust's intranet site.

12.2 Quarterly memos are sent to line managers to disseminate to their staff the most currently approved guidelines available via the intranet and clinical guideline folders, located in each designated clinical area.

12.3 Guideline monitors have been nominated to each clinical area to ensure a system whereby obsolete guidelines are archived and newly approved guidelines are now downloaded from the intranet and filed appropriately in the guideline folders. 'Spot checks' are performed on all clinical guidelines quarterly.

12.4 Quarterly Clinical Practices group meetings are held to discuss 'guidelines'. During this meeting the practice development midwife can highlight any areas for future training needs will be met using methods such as 'workshops' or to be included in future 'skills and drills' mandatory training sessions.

13.0 Communication

13.1 A quarterly 'maternity newsletter' is issued to all staff to highlight key changes in clinical practice to include a list of newly approved guidelines for staff to acknowledge and familiarise themselves with and practice accordingly. Midwives that are on maternity leave or 'bank' staff have letters sent to their home address to update them on current clinical changes.

13.2 Approved guidelines are published monthly in the Trust's Staff Focus that is sent via email to all staff.

13.3 Approved guidelines will be disseminated to appropriate staff quarterly via email.

13.4 Regular memos are posted on the guideline and audit notice boards in each clinical area to notify staff of the latest revised guidelines and how to access guidelines via the intranet or clinical guideline folders.

14.0 References

Abotalib, Zoinab (2008) Anatomy of the Female Bony Pelvis and Fetal Skull. www.fertility2.com November.

National Childbirth Trust, Royal College of Midwives, Royal College of Obstetricians: Making Normal Birth a Reality (2007).

National Institute for Health and Care Excellence (2014) Intrapartum care for healthy women and babies. nice.org.uk/guidance/cg190

National Institute for Health and Care Excellence (2008) Antenatal Care for uncomplicated pregnancies.nice.org.uk/guidance/cg62

NHSLA Clinical Negligence Scheme for Trusts Maternity Clinical Risk Management Standards 2008.