Module Presentation

How to best use the Modules

To make the best use of this training we encourage you to complete each Module in order following the format below:

1. Read *Module Presentation*. Added explanations can be found in the HELPER Guidelines and in the extra information section if there is one.
2. Complete the *Extraction/Scenario* training exercises
   The extraction exercises use de-identified and altered patient medical records. The information is then entered into the provided section from the Birth Certificate Workbook.
   The Scenarios are situations you may encounter as you collect information from your patients' medical records.
3. Check your responses using the answer sheets in the "Answers" section.
4. Complete the Module specific *Evaluation*, faxing or emailing the completed evaluation to: rosemary_varga@urmc.rochester.edu.
   We will use these evaluations to identify areas where the training can be improved.
5. If not already done, read extra training materials, if available.

If you have questions about how to answer any of the requests for information in the NYS Certificate of Live Birth Training Modules,

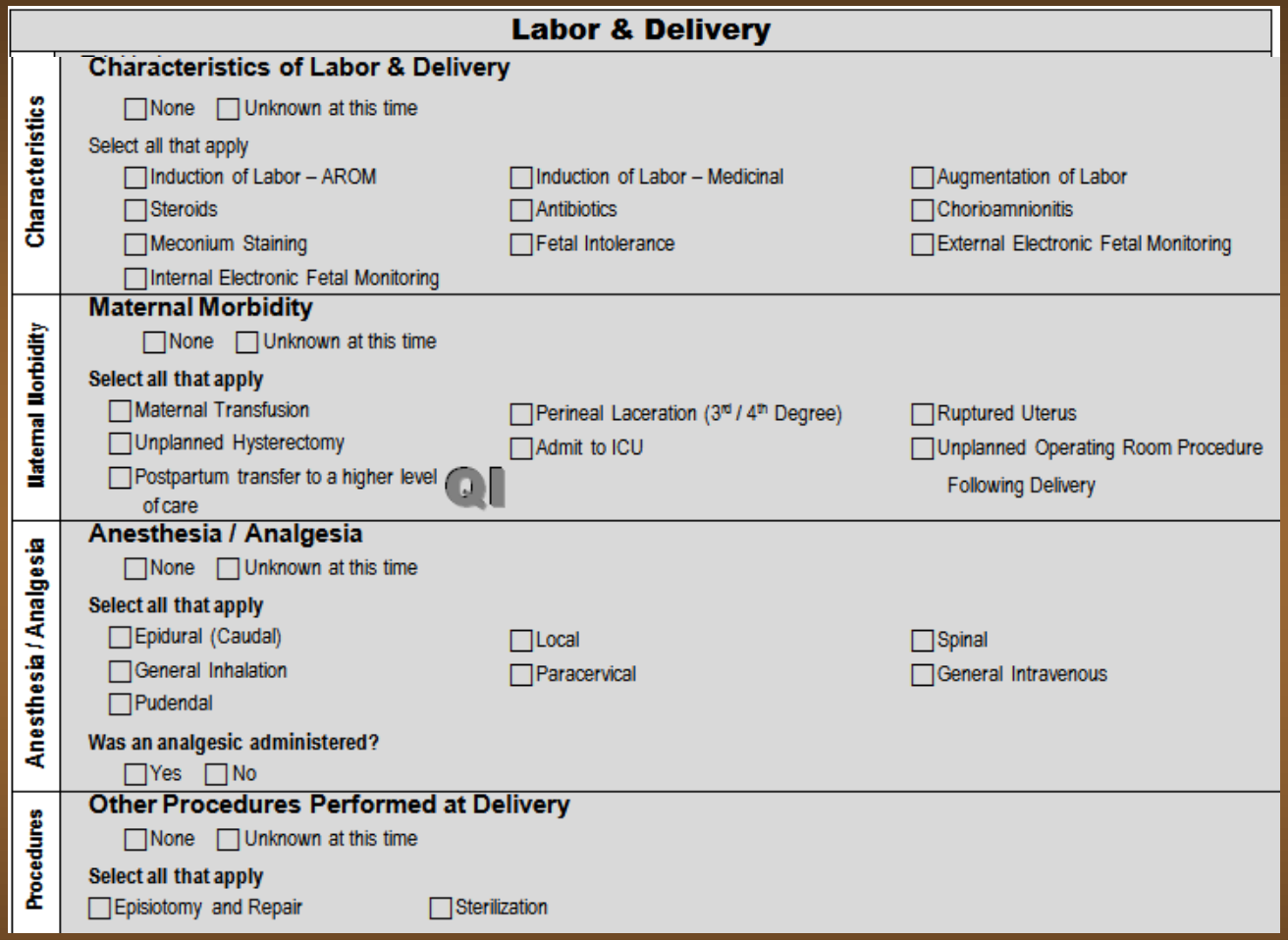
Please, contact Rosemary Varga (585-275-8737).

*"Coding" is a convenient although slightly misleading term for entering the needed information in the Statewide Perinatal Data system. True "coding" is the entry of predetermined numbers into a system that can then rate the material. We do not use numbers rather we enter the requested information.

Module Four

Labor & Delivery Part II

Labor & Delivery Fields



Labor & Delivery

Characteristics

Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Induction of Labor – AROM	☐ Induction of Labor – Medicinal	☐ Augmentation of Labor
☐ Steroids	☐ Antibiotics	☐ Chorioamnionitis
☐ Meconium Staining	☐ Fetal Intolerance	☐ External Electronic Fetal Monitoring
☐ Internal Electronic Fetal Monitoring		

Maternal Morbidity

Maternal Morbidity

☐ None ☐ Unknown at this time

Select all that apply

☐ Maternal Transfusion	☐ Perineal Laceration (3rd / 4th Degree)	☐ Ruptured Uterus
☐ Unplanned Hysterectomy	☐ Admit to ICU	☐ Unplanned Operating Room Procedure Following Delivery
☐ Postpartum transfer to a higher level of care		

Anesthesia / Analgesia

Anesthesia / Analgesia

☐ None ☐ Unknown at this time

Select all that apply

☐ Epidural (Caudal)	☐ Local	☐ Spinal
☐ General Inhalation	☐ Paracervical	☐ General Intravenous
☐ Pudendal		

Was an analgesic administered?

☐ Yes ☐ No

Procedures

Other Procedures Performed at Delivery

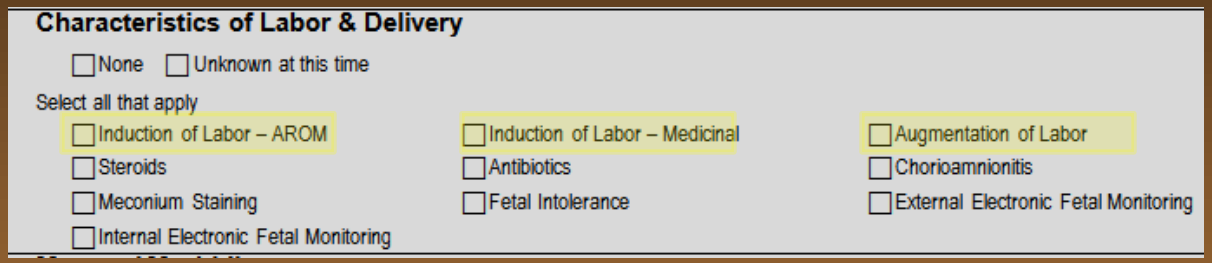
☐ None ☐ Unknown at this time

Select all that apply

☐ Episiotomy and Repair ☐ Sterilization

Labor & Delivery information will be found in the mother's chart with much of the information found on the L & D flowsheet/summary (a copy of which may also be in the infant's chart).

Characteristics of Labor & Delivery



Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Induction of Labor – AROM	☐ Induction of Labor – Medicinal	☐ Augmentation of Labor
☐ Steroids	☐ Antibiotics	☐ Chorioamnionitis
☐ Meconium Staining	☐ Fetal Intolerance	☐ External Electronic Fetal Monitoring
☐ Internal Electronic Fetal Monitoring		

Intent is key when determining induction vs. augmentation. If the goal is to get labor started then it's induction. If it's used to help the progress of labor that has already started then its considered to be augmentation.

See detailed discussion of Induction VS Augmentation on Slides 4 -7

NYS GUIDELINES

- **Induction of Labor – AROM** Initiation of uterine contractions by surgical means for the purpose of promoting delivery before spontaneous onset of labor. Synonyms include: artificial rupture of membranes, amniotomy. If AROM was done to augment labor that should be reported under Augmentation of Labor.
- **Induction of Labor – Medical** Initiation of uterine contractions by administration of medications (e.g. pitocin, prostaglandin) for the purpose of promoting delivery before spontaneous onset of labor.
- **Augmentation of Labor** – Simulation of uterine contractions by drug or manipulative technique with the intent to reduce the time to delivery.

Terms:
AROM= Artificial rupture of membranes (artificial rupture of the amniotic sac) can be used to induce or augment labor. Don't code if used only to facilitate delivery or to place a scalp electrode **(see slide 6)**
IOL= Induction of labor

If oxytocin (Pitocin) is the initial induction agent, the induction should be coded as medicinal, even if AROM is performed later. If AROM is performed first but does nothing and oxytocin is then added, select both medicinal and AROM as induction fields.

Induction vs. Augmentation

- **Intent is key when deciding whether the labor assistance a mother receives is augmentation or induction.**
- If a woman not in labor is admitted for the purpose of getting labor started, it is an induction, whether the means is oxytocin, prostaglandins, AROM, "EASI" (Cervical foley) or laminaria.
- Augmentation is used when someone in dysfunctional labor (i.e. already in some semblance of labor – generally spontaneous in onset- but inadequate for normal progress) is given additional help to get the process going, usually either with oxytocin or AROM.
- Active labor= regular contractions with cervical changes

Induction vs. Augmentation

(continued)

- If a woman is induced, it is rare that she also should be coded as being augmented (i.e. if you are unsure, induction trumps augmentation).
- The main exception would be an AROM induction in which contractions ensue but not enough for adequate labor.
  - If the cervix has changed at least somewhat, use of oxytocin under this circumstance would be augmentation.
  - Without any cervical change following AROM, adding oxytocin would be better coded as an agent of induction, even though AROM was the initial effort.
  - Following initial, continued use of oxytocin for induction, subsequent AROM does not constitute augmentation.

Induction vs. Augmentation

(continued)

- Whether or not cervical ripening is used, if oxytocin is the initial induction agent, the Induction should be coded as medicinal, even if AROM is performed later. If AROM is performed first but nothing happens and oxytocin subsequently is added, they may both be listed as induction agents (i.e., select both medicinal and AROM induction fields).
- **Bear in mind that AROM may be done for many reasons, only one of which is augmentation.** Other reasons include facilitating placement of a scalp electrode, to check for meconium, to allow the head to descend, and because it's going to happen eventually anyway.
  - –Often an obstetrician's threshold for rupturing membranes is low and minor deviations in the labor curve will lead to AROM even though the labor pattern may not have been dysfunctional per se.

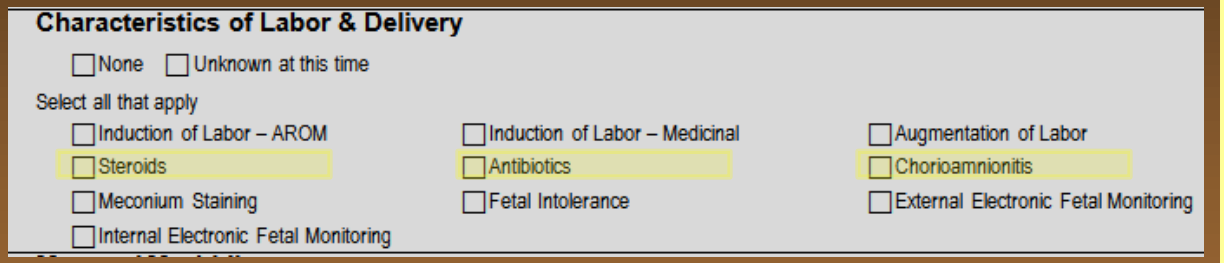
Induction vs. Augmentation

(continued)

A dose of Pitocin is generally given to the mom after delivery to help the uterus contract and is NOT considered Induction or Augmentation. Be sure to note the time the Pitocin is given in relationship to the time of delivery.

Characteristics of Labor & Delivery

(continued)



Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Induction of Labor – AROM	☐ Induction of Labor – Medicinal	☐ Augmentation of Labor
☐ Steroids	☐ Antibiotics	☐ Chorioamnionitis
☐ Meconium Staining	☐ Fetal Intolerance	☐ External Electronic Fetal Monitoring
☐ Internal Electronic Fetal Monitoring		

Terms:
Chorioamnionitis is an inflammation of the fetal membranes due to a bacterial infection. It typically results from bacteria ascending into the uterus from the vagina and is most often associated with prolonged labor.

NYS GUIDELINES

- **Steroids** – (glucosteroids) Steroids given any time prior to delivery for fetal lung maturation received by the mother prior to delivery. Includes betamethasone, dexamethasone or hydrocortisone specifically given to accelerate fetal lung maturation in anticipation of preterm delivery. Excludes steroid medication given to mother as an anti-inflammatory treatment.
- **Antibiotics** - This includes antibiotics given to the mother during labor. It includes antibacterial medications given systemically (intravenous or intramuscular) to the mother in the interval between the onset of labor and the actual delivery (Ampicillin, Penicillin, Clindamycin, Erythromycin, Gentamicin, Cefataxime, Ceftriaxone, etc.).
- **Chorioamnionitis** A clinical diagnosis of chorioamnionitis during labor made by the delivery attendant. Usually includes more than one of the following: fever (> 100.4 F or 38 C), uterine tenderness and/or irritability, leukocytosis, and fetal tachycardia. Any recorded maternal temperature at or above the febrile threshold as stated should be reported. However, do not report a single temperature elevation with a good alternative explanation.

Only antibiotics administered during labor and delivery should be coded. <u>Antibiotics used routinely for prophylaxis during a C-section should not be coded.</u>

Watch for use of Betamethasone. This steroid if often given when preterm birth is threatened, to assist in the development of the infant's lungs

Characteristics of Labor & Delivery
(continued)

Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Induction of Labor – AROM	☐ Induction of Labor – Medicinal	☐ Augmentation of Labor
☐ Steroids	☐ Antibiotics	☐ Chorioamnionitis
☐ Meconium Staining	☐ Fetal Intolerance	☐ External Electronic Fetal Monitoring
☐ Internal Electronic Fetal Monitoring		

NYS GUIDELINES

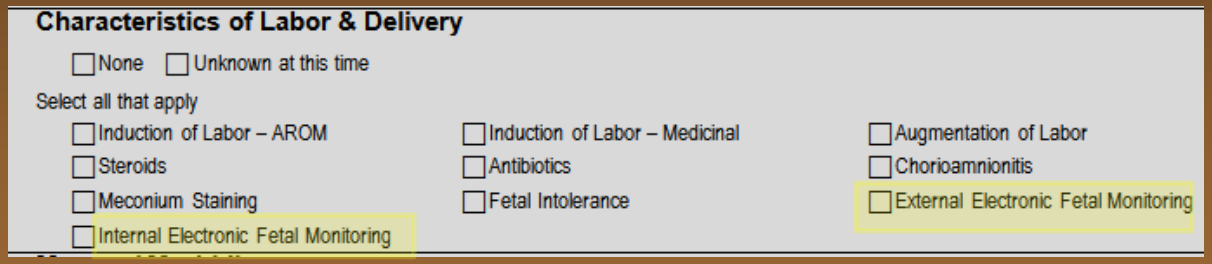
- **Meconium staining** Staining of the amniotic fluid caused by passage of fetal bowel contents during labor and/or delivery which is more than enough to causea greenish color change of an otherwise thin fluid, reguardless of the characteristics of the meconium.
- **Fetal intolerance** of labor such that one or more of the following actions was taken : in-utero resuscitation measures, further fetal assessment or operative delivery; *In utero resuscitative measure-s* such as any of the following: maternal position change, oxygen administration to the mother, intravenous fluid administered to the mother, amnioinfusion, support of maternal blood pressure, and administration of uterine relaxing agents. *Further fetal assessment* includes any of the following: scalp pH, scalp stimulation, acoustic stimulation. *Operative delivery*-operative intervention to shorten time to delivery of the fetus such as forceps, vacuum, or cesarean delivery. The symptoms described and the measures used to treat them may be seen with administration of regional analgesia. However, if any of the measures listed in the Guide are documented in the chart, the response should be 'YES'. An isolated episode with a good alternative explanation that resolves readily should not be reported.

Terms:
Meconium is the content of the fetal bowel. Unlike later feces, meconium is composed of sloughed cells from the intestinal mucosa as well as swallowed amniotic fluid debris. Meconium normally is stored in the infant's bowel until after birth, but sometimes it is expelled into the amniotic fluid prior to birth or during labor. When this happens it is seen as a sign of fetal distress.

Read carefully so you don't miss signs of fetal intolerance!

You may see the term – "terminal meconium" used. Terminal meconium is meconium passed just before the actual delivery rather than during early labor or in the antepartum period. Terminal meconium in addition to all other types of meconium should be coded in this field

Characteristics of Labor & Delivery
(continued)



Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Induction of Labor – AROM	☐ Induction of Labor – Medicinal	☐ Augmentation of Labor
☐ Steroids	☐ Antibiotics	☐ Chorioamnionitis
☐ Meconium Staining	☐ Fetal Intolerance	☐ External Electronic Fetal Monitoring
☐ Internal Electronic Fetal Monitoring		

Terms:
EFM= External fetal Monitor
IFM= Internal Fetal Monitor

NYS GUIDELINES

- **External Electronic Fetal Monitoring** Use of a non-invasive fetal monitoring device to track fetal heart rate during labor and/or delivery.
- **Internal Electronic Fetal Monitoring** Use of an internal fetal monitoring device (synonym: scalp electrode) to track fetal heart rate during labor and/or delivery.

External Fetal Monitor <u>used routinely, on admission only, should NOT be coded.</u>

*IUPC (Intrauterine Pressure Catheter) measures contractions and is NOT considered fetal monitoring

Mention of 'reactive fetal heart tones' in the notes implies use of electronic monitoring (you will need to determine whether external or internal)

Maternal Morbidity

Maternal Morbidity

☐ None ☐ Unknown at this time

Select all that apply

- ☐ Maternal Transfusion
- ☐ Unplanned Hysterectomy
- ☐ Postpartum transfer to a higher level of care
- ☐ Perineal Laceration (3rd / 4th Degree)
- ☐ Admit to ICU
- ☐ Ruptured Uterus
- ☐ Unplanned Operating Room Procedure Following Delivery

NYS GUIDELINES

- **Maternal transfusion** Includes infusion of whole blood or packed red blood cells associated with labor and delivery.
- **Perineal laceration (3rd or 4th degree)** 3rd degree laceration extends completely through the perineal skin, vaginal mucosa, perineal body and anal sphincter. 4th degree laceration is all of the above with extension through the rectal mucosa.
- **Ruptured uterus** Tearing of the uterine wall.
- **Unplanned Hysterectomy** Surgical removal of the uterus that was not planned prior to admission for delivery. Includes an anticipated or possible but not definitively planned procedure.
- **Admit to ICU** Any admission, planned or unplanned, of the mother to a facility/unit designated as providing intensive care.
- **Unplanned operating room procedure following delivery** Any transfer of the mother back to a surgical area for an operative procedure that was not planned prior to the admission for delivery. Excludes postpartum tubal ligations.
- **Postpartum transfer to a higher level of care**
  - For maternity hospital deliveries: select this item if the mother was transferred to another hospital following delivery in order to provide her with more specialized or intensive care than available on the maternity service where she delivered.
  - For planned out-of-hospital deliveries (e.g. birthing center, planned home birth): select this item if mother required admission to a hospital following delivery.
  - For unplanned out-of-hospital or non-maternity hospital deliveries: Do not select this item if the mother was admitted to a maternity hospital after giving birth precipitously at home, en route to the hospital, or at a non-maternity hospital.
- **None** Select this item if none of the items listed are selected, even if other maternal morbidity conditions exist.
- **Unknown at this time**

Only 3rd or 4th degree lacerations are coded.

Anesthesia/Analgesia

Code all types of anesthesia used during labor & delivery

Anesthesia / Analgesia

☐ None ☐ Unknown at this time

Select all that apply

☐ Epidural (Caudal)
☐ General Inhalation
☐ Pudendal
☐ Local
☐ Paracervical
☐ Spinal
☐ General Intravenous

Was an analgesic administered?

☐ Yes ☐ No

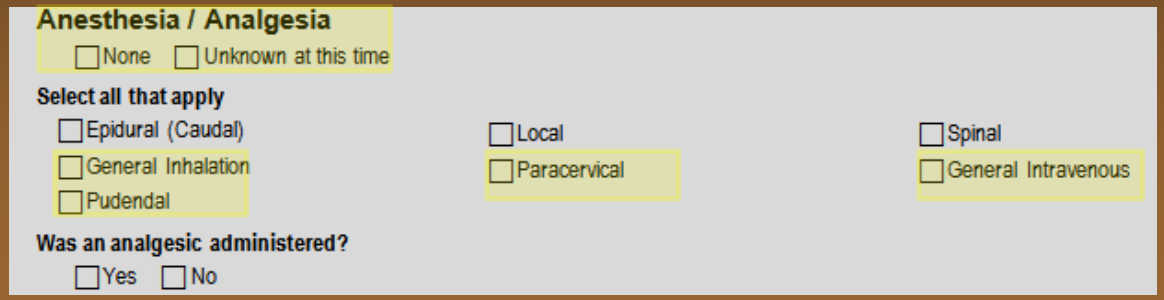
NYS GUIDELINES

ANESTHESIA USED FOR DELIVERY

Indicate all types of anesthesia used during this labor and/or delivery. Anesthesia is a medication or other agent used to cause a loss of feeling (loss of sensation of pain). Report only the type of anesthesia used during labor and delivery, not the anesthetic agent.

- **Epidural:** Select this item if the denervation of the vaginal region and lower abdomen was obtained by the introduction of an anesthetic agent into the epidural or peridural space.
- **Local:** Select this item if the denervation of the vaginal area was obtained by the introduction of an anesthetic agent into the perineum for the provision of an episiotomy or repair of a laceration or episiotomy wound.
- **Spinal:** Select this item if the denervation of the vaginal region was obtained by the introduction of an anesthetic agent into the subarachnoid space. Synonyms include saddle block. Intrathecal (spinal) analgesia (narcotic +/- a small amount of local anesthetic), also called "intrathecal Duramorph," should be reported here AND as "Analgesia," since it carries risks and side effects of both.

Anesthesia/Analgesia



NYS GUIDELINES

- **General Inhalation:** Select this item if there was the reduction of pain over the entire body induced by respiration of a gaseous anesthetic agent.
- **Paracervical:** Select this item if the denervation of the vaginal region was obtained by the introduction of an anesthetic agent to the tissues surrounding the cervix of the uterus.
- **General Intravenous**: Select this item if there was the reduction of pain over the entire body induced by the introduction of an anesthetic agent into a vein.
- **Pudendal:** Select this item if the denervation of the pudendal nerve was obtained by an injection of an anesthetic agent.
- **None** Select this item if none of the items listed are selected.
- **Unknown at this time**

General inhalation will almost always be preceded by general intravenous. Always Select both General Intravenous and General Inhalation when anesthesia is described as “General”, “General Intravenous” or “General Inhalation”.

The objective of this item is to collect information on mothers who receive anesthesia to control pain during the LABOR process only, so any anesthesia administered during recovery or at any time post-delivery would not be reported.

Anesthesia/Analgesia

Anesthesia / Analgesia

☐ None ☐ Unknown at this time

Select all that apply

☐ Epidural (Caudal) ☐ Local ☐ Spinal

☐ General Inhalation ☐ Paracervical ☐ General Intravenous

☐ Pudendal

Was an analgesic administered?

☐ Yes ☐ No

- Code use of analgesics during labor & delivery

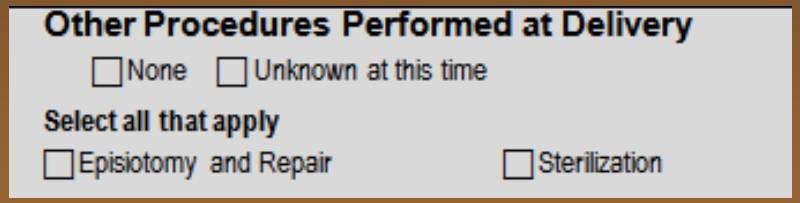
NYS GUIDELINES

ANALGESIA

Select "yes" for analgesia if during labor and/or delivery the mother received an analgesic medication, that is, one that decreases the sensation of pain (relief of pain). It may include any narcotic or non-narcotic painkiller. A sedative, that is, a substance that calms activity or excitement, does not qualify as analgesia when administered alone. Intrathecal (spinal) analgesia (narcotic +/- a small amount of local anesthetic), also called "intrathecal Duramorph," should be reported here AND as "Anesthesia, Spinal," since it carries risks and side effects of both. Exclude analgesics administered during other procedures performed after delivery such as episiotomy or laceration repair.

If a mom receives spinal anesthesia for a C-section, even if she was not in labor and was not experiencing any pain at the time of administration, code both "analgesia" and "spinal anesthesia" when analgesia such as Fentanyl is used in the spinal/epidural.

Other Procedures


Other Procedures Performed at Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Episiotomy and Repair ☐ Sterilization

NYS GUIDELINES

OTHER PROCEDURES PERFORMED AT DELIVERY

Record the procedures performed at the time of delivery or during the birth hospitalization.

- **Episiotomy & Repair** Select this procedure if an incision was made to enlarge the vaginal opening and then repaired.
- **Sterilization** Select this procedure if at any time during the birth hospitalization the mother received any procedure that permanently prevented future pregnancies. Synonyms include bilateral tubal ligation (BTL), hysterectomy, laparoscopic tubal ligation, oophorectomy, pomeroy, salpingectomy, tubal ligation.
- **None** Select this item if none of the items listed are selected.
- **Unknown at this time**

The
End

Extraction Exercises

Module 4 – L&D II

Extraction Exercise #1

Below are abridged chart notes and an abridged example of a patient summary created for Birth Certificate Registrars. You will only be entering data for the second half of the L&D portion of the work book.
Fill in the appropriate answers on the Birth Certificate Work Book excerpts (last page).

Chart note 1 – Attending Admit note:

- Admit for Cesarean delivery.
- This is patient's first Cesarean.
- Indication for cesarean is: twins
- We discussed, again, the risks/benefits and alternatives including: Trial of Labor (TOL) leading to vaginal delivery, scheduled Cesarean delivery, TOL leading to a Cesarean delivery.
- Discussed the risks of Cesarean, including infection, need for repeat surgery, scarring increasing with each surgery, the need for additional surgery in the future, abnormal placentation, blood transfusion, maternal complications, anesthesia complications, etc.
- The patient is not interested in TOL
- We discussed the need to limit the number of future pregnancies for repeated cesarean deliveries, that risks increase with each cesarean delivery, and that the decision between these two options should including consideration of eventual family size planning.
- Maternal and fetal risks and benefits of scheduled delivery between 36 0/7 and 38 6/7 weeks were discussed with the mother.
- Patient and family denied questions at this time.

Chart Note 2 Anesthesia Pre-operative History and Physical

- Patient is a 21 yr. female scheduled for a primary C/S for mono-di twins.
- Asthma - uses albuterol inhaler about once a week, feels tight today (but states that occurs when she is nervous, and she does not take her inhaler for that, lungs clear today)
- Anemia - obtained blood work today
- No recent sicknesses within the past 2.5 months
- No HTN
- No issues with anesthesia that run in the family (she herself had not had general anesthesia)
- Two vessel cord on U/S with this pregnancy and a fetal cardiac echogenic focus
- Allergy to morphine - swelling of lips, explained this would not be used, consented for bilateral TAP blocks for postop pain relief

Chart Note 3 – Attending C-section note

21 yr. G4P0120 at 37w0d who presented for scheduled pLTCS with pregnancy complicated by MonoDi twins. She was counseled on delivery modalities, and elected for pLTCS. She delivered Baby A, a viable female infant, with weight of 2510g, Apgars 9/9, at one and five minutes respectively. She then delivered Baby B, a viable female infant, with weight of 2720g, Apgars 8/8, at one and five minutes respectively. Her procedure was uncomplicated. EBL 900 cc. Pt. tolerated procedure well, recovering in labor and delivery.

Dating Summary

Working EDD: 01/24/XX set by RN on 06/07/XX based on Last Menstrual Period on 04/19/XX

Based On	EDD	GA Dif	GA	User	Date
Last Menstrual Period on 04/19/XX	01/24/XX	Working		RN	06/07/XX

(Exact Date)					
Ultrasound on 07/14/XX	01/28/XX	-4d	11w5d MD		12/20/XX

OB History

Gravida	Para	Term	Preterm	AB	TAB	SAB	Ectopic	Multiple	Living
4	2	1	1	2	0	2	0	1	2

#	Outcome	Date	GA	Labor/2nd	Weight	Sex	Delivery	Anes	PTL	Living	Name	Location	Delivering Clinician
1	Spontaneous Abortion	02/XX					SAB				4w		
Birth Comments: No D&S required													
2	Preterm	12//	22w5d		360 g (12.7 oz)	F	Vag-Spont	EPI	N	N		Other	MD
Birth Comments: IOL for fetal acrania													
3	Spontaneous Abortion	03/XX	6w0d				SAB						
Birth Comments: no complications													
4A	Term	01/XX	37w0d		2510 g (5 lb 8.5 oz)	F	CSLT	SPINAL-	N	Y	GIRL A	Other	MD
4B	Term	01/XX	37w0d		2720 g (5 lb 15.9 oz)	F	CSLT	SPINAL-	N	Y	GIRL B	Other	MD

OB Episode Encounters

Encounters related to Labor and Delivery Encounter on 1/3/XX with MD

Date	Encounter Type	Provider	Department	Reason
1/3/XX	Labor and Delivery Encounter	MD	OB	Not found
1/3/XX	Labor and Delivery Encounter	MD	OB	Twin gest- Monochorionic diamniotic twin gestation in third trimester
1/3/XX	Anesthesia Event	MD	OB	Not found
1/3/XX	Surgery	MD	OB	C-SECTION, prim, mono/di twins
1/3/XX	Procedure Pass	Not found	OB	Not found
1/3/XX	Anesthesia	MD	OB	Not found
1/3/XX	History	MD	OB	Not found
12/27/XX	Routine Prenatal	DO	OB	OB CHECK; ROUTINE PRENATAL VISIT-
12/20/XX	Initial Prenatal	MD	OB	NEW OB VISIT; INITIAL PRENATAL VISIT
12/XX/XX	Labor and Delivery Encounter	MD	OB	Not found
12/14/XX	Labor and Delivery Encounter	MD	OB	Not found

12/8/XX	Routine Prenatal Clinical Support	PERINATAL, NONSTRESS TST	OB	NON-STRESS TEST
11/29/XX	Routine Prenatal	MD	OB	OB CHECK - NO CHARGE; ROUTINE PRENATAL VISIT
11/11/XX	Routine Prenatal	NP	OB	OB CHECK - NO CHARGE; ROUTINE PRENATAL VISIT
10/27/XX	Labor and Delivery Encounter	MD	OB	Not found
10/7/XX	Labor and Delivery Encounter	MD	OB	Not found
9/26/XX	Routine Prenatal	MD	OB	OB CHECK - NO CHARGE; ROUTINE PRENATAL VISIT
8/31/XX	Routine Prenatal	MD	OB	OB CHECK - NO CHARGE; ROUTINE PRENATAL VISIT
8/XX/XX	Routine Prenatal	MD	OB	OB CHECK - NO CHARGE; ROUTINE PRENATAL VISIT
8/3/XX	Routine Prenatal	NP	OB	OB CHECK - NO CHARGE; ROUTINE PRENATAL VISIT
7/27/XX	Routine Prenatal	CNM	OB	OB CHECK - NO CHARGE; ROUTINE PRENATAL VISIT
6/23/XX	Initial Prenatal	CNM	OB	NEW OB; INITIAL PRENATAL VISIT
6/7/XX	Initial Prenatal Clinical Support	RN	OB	NEW PATIENT INTAKE (NC); INITIAL PRENATAL VISIT

Hospital Problems

		Priority	Class	Noted - Resolved
Active Problems				
S/P primary low transverse C-section				1/3/XX - Present
Resolved Problems				
RESOLVED: Monochorionic diamniotic twin gestation				7/27/XX - 1/3/XX
RESOLVED: Twin gest-monochr/diamni				1/3/XX - 1/3/XX

Non-Hospital Problems

		Priority	Class	Noted - Resolved
Active Problems				
Asthma				8/22/XX - Present
Health care maintenance				9/29/XX -

		Present
Marijuana use		7/19/XX - Present
Supervision of normal pregnancy		7/19/XX - Present
Previous child with congenital anomaly, currently pregnant, antepartum		8/3/XX - Present
Labile blood pressure		8/3/XX - Present
Depression with anxiety		8/XX/XX - Present
Bipolar disease during pregnancy		8/XX/XX - Present
Fetal cardiac echogenic focus		8/31/XX - Present
Anemia affecting pregnancy		11/13/XX - Present
Irregular uterine contractions		12/14/XX - Present
Two vessel umbilical cord		12/21/XX - Present
Domestic violence affecting pregnancy		12/21/XX - Present

Resolved Problems

RESOLVED: Teen pregnancy	High	8/22/XX - 9/29/XX
RESOLVED: Fetal developmental abnormality	High	9/27/XX - 9/29/XX
RESOLVED: Vaginal delivery	High	12/4/XX - 9/29/XX
RESOLVED: Insufficient prenatal care		11/4/XX - 9/29/XX
RESOLVED: Flu vaccine need		11/14/XX - 9/29/XX

Medical History

Past Medical History	Date	Comments
Asthma [J45.909]		**no hospitalizations or intubations, albuterol prn**
Constipation [K59.00]	**7/XX**	**Hospitalized for one week at another hospital**
Anxiety [F41.9]		
Depression [F32.9]		
Depression [F32.9]		
Bipolar disorder [F31.9]		
Physical abuse of adult by partner [T74.11XA]		
Sexual abuse of adult by partner [T74.21XA]		
Adult emotional/psychological abuse [T74.31XA]		

Marijuana smoker [F12.20]		
Chlamydia [A74.9]		
Screening for cystic fibrosis [Z13.228]	**?**	**no mutation**

Surgical History

Past Surgical History	Laterality	Last Occurrence	Comments
None			

Social History

Category	History
Smoking Tobacco Use	**Current Every Day Smoker; Start date: ; Last attempt to quit: 7/1/XX; 0.25 packs/day; Types: Cigarettes**
Smokeless Tobacco Use	**Former User; Quit date:**
Tobacco Comment	**Reports as of 8/31/XX that she is not smoking**
Alcohol Use	**No**
Drug Use	**Yes; Types: Marijuana**
Sexual Activity	**Yes; Male, Female partners; Birth Ctrl/Protection: None**
ADL	**Not Asked**

Concurrent Nursing Documentation Maternal Information

ABO RH BLOOD TYPE

Date	Value	Ref Range	Status
01/03/XX	A RH POS		Final

HBV S AG

Date	Value	Ref Range	Status
07/14/XX	NEG		Final

Comment:
Test Method: CMIA

RUBELLA IGG AB

Date	Value	Ref Range	Status
07/14/XX	POSITIVE		Final

Comment:
TEST METHOD: Multiplex flow immunoassay

HIV 1&2 AB SCREEN

Date	Value	Ref Range	Status
08/22/XX	NEG		Final

Comment:
TEST METHOD: EIA

HIV 1&2 ANTIGEN/ANTIBODY

Date	Value	Ref Range	Status
07/14/XX	Nonreactive		Final

Comment:
Test Method: CMIA

SYPHILIS SCREEN

Date	Value	Ref Range	Status
01/03/XX	Neg		Final

Comment:
TEST METHOD: BioPLEX(Multiplex Flow Immunoassay)

GROUP B STREP CULTURE

Date	Value	Ref Range	Status

12/14/XX . Final

Facility-Administered Medications as of 1/5/XX

Medication	Dose	Frequency	Last Dose

Chromosome Analysis

**** No results found for the last 7440 hours. ****

Weights (since admission)

Date/Time	Height	Weight	PrePregnancy Weight	Pregnancy weight change (kg)	BMI (Calculated)	BSA (Calculated - sq m)	Who
01/03/XX 0800	1.524 m (5')	93 kg (205 lb)	54.4 kg (120 lb)	38.56 kg	40.1	1.98 sq meters	

Nursing Epidural Events

None

Anesthesia Record

Anesthesia Record

Steroidal Medications (Filter: ERX GENERAL PQRI GLUCOCORTICOID MEDICATIONS MEASURE 180 Medications Shown)

None

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
01/03/XX 0735	Admission	Inpatient	OB	OB	Surgery
01/03/XX 0739	Patient Update	Inpatient	OB	OB	Surgery
01/03/XX 0940	Surgery	Surgery Admit	OB OR	S_OR	OBGYN
01/03/XX 1026	Patient Update	Inpatient	OB	OB	Surgery

Girl A

Delivery Information

Girl A Sex: female Gestational Age: 37w0d MRN: _____ **PCP:** MD
Delivery Date/Time: 1/3/XX
Time of Head Delivery: 1/3/XX 10:26 AM
Delivery Type: C-Sec, Low Transverse Meconium at time of delivery: none
Delivery Location: OB OR

Labor Onset Date/Time: Dilation Complete Date/Time:
Preterm labor: No **Antenatal steroids:** None **Antibiotics received during labor:** No
First Cervical ripening date/time: / **Cervical ripening Type:**

Rupture Date: 1/3/XX **Rupture Time:** 10:26 AM **Details: Rupture Type:** Artificial **Color:** Clear **Amount:** Moderate
Induction:
Indications: Augmentation: .None
Labor complications: None

OBDELIVERYPROVIDERS **Anesthesia Method:** Spinal- **Analgesics:**
Presentation: Vertex **Position:** Right Occiput Posterior
Prophylactic Maneuver: No

Shoulder Dystocia: No
Resuscitation: Dry; Tactile Stimulation; Bulb Suctioning
Living Status: Yes

APGARs	Total	Color	Reflex irritability	Breath	Heart Rate	Muscle Tone	Assigned By (greater than 7 no need for next measurement)
1 min	9	1	2	2	2	2	RNC
5 min	9	1	2	2	2	2	RNC
10 min							
15 min							
20 min							
25 min							
30 min							

Birth Weight: Height: Head Circumference: Observed Anomalies:
Cord: 2 Vessels Complications: NONE Clamping Delayed: 0 Clamped Date/Time:1/3 10:26 AM Cord blood disposition: Lab Gases sent: No Stem cell collection -by MD-: No
Maternal Info:
Placenta Delivery Date/Time: 1/3 10:29 AM Removal: C-Section Removal Appearance: Intact Disposition: pathology
Bonding:
Stages of Labor: Stage One: h m Stage Two: 0h 0m Stage Three: 0h 3m
Episiotomy: None
Perineal lacerations:
Delivery est. blood loss (mL):
Procedures: None

*Labor Events

Preterm labor?: No
Rupture date: 1/3/XX
Rupture type: Artificial
Rupture Time: 10:26 AM
Induction: .None
Augmentation: .None

Hospital Problems

	Priority	Class	Noted - Resolved
Active Problems			
Neonatal hypoglycemia			1/4/XX - Present
Observation and evaluation of newborn for suspected infectious condition			1/4/XX - Present
Hypothermia			1/4/XX - Present

Non-Hospital Problems

None

Concurrent Nursing Documentation Newborns

Concurrent Nursing Documentation
Newborn Hearing Rt Ear Results: Pass
Newborn Hearing Lt Ear Results: Pass
Hepatitis B Vaccine:: Refused

There is no immunization history on file for this patient.

Pertussis educational material presented to patients family concerning Pertussis vaccination availability. (Year-Round)
Pertussis Edu Material Presented : Yes
Influenza educational material presented to patients family concerning Influenza vaccination availability.(FLU season only)
Influenza Edu Material Presented : Yes

Antibiotics (Filter: RX BROAD SPECTRUM ABX Medications Shown)

None

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
01/03/XX 1026	Admission	Inpatient	NBN	NBN	
01/04/XX 1221	Transfer Out	Inpatient	NICU	NBN	
01/04/XX 1221	Transfer In	Inpatient	NBN	NBN	

Girl B

Delivery Information

Girl B Sex: female Gestational Age: 37w0d MRN: _____ **PCP:** MD
Delivery Date/Time: 1/3/XX
Time of Head Delivery: 1/3/XX 10:27 AM
Delivery Type: C-Sec, Low Transverse Meconium at time of delivery: none
Delivery Location: OB OR

Labor Onset Date/Time: Dilation Complete Date/Time:
Preterm labor: No **Antenatal steroids:** None **Antibiotics received during labor:** No
First Cervical ripening date/time: / **Cervical ripening Type:**
Rupture Date: 1/3/XX **Rupture Time:** 10:26 AM **Details: Rupture Type:** Artificial **Color:** Clear **Amount:** Large
Induction:
Indications: Augmentation: .None
Labor complications: None

OBDELIVERYPROVIDERS **Anesthesia Method:** Spinal- **Analgesics:**
Presentation: Vertex **Position:** Right Occiput Transverse
Prophylactic Maneuver: No

Shoulder Dystocia: No
Resuscitation: Dry; Tactile Stimulation; Bulb Suctioning
Living Status: Yes

APGARs	Total	Color	Reflex irritability	Breath	Heart Rate	Muscle Tone	Assigned By (greater than 7 no need for next measurement)
1 min	8	0	2	2	2	2	RNC
5 min	8	0	2	2	2	2	RNC
10 min							
15 min							

20 min							
25 min							
30 min							

Birth Weight: Height: Head Circumference: Observed Anomalies:
Cord: 3 Vessels Complications: NONE Clamping Delayed: 0 Clamped Date/Time:1/3 10:27 AM Cord blood disposition: Lab Gases sent: No Stem cell collection -by MD-: No
Maternal Info:
Placenta Delivery Date/Time: 1/3 10:29 AM Removal: C-Section Removal Appearance: Intact Disposition: pathology
Bonding:
Stages of Labor: Stage One: h m Stage Two: 0h 0m Stage Three: 0h 2m
Episiotomy: None
Perineal lacerations:
Delivery est. blood loss (mL):
Procedures: None

*Labor Events

Preterm labor?: No
Rupture date: 1/3/XX
Rupture type: Artificial
Rupture Time: 10:26 AM
Induction: .None
Augmentation: .None

Hospital Problems

	Priority	Class	Noted - Resolved

Active Problems

37 or more completed weeks of gestation			1/4/XX - Present
Twin, mate liveborn, born in hospital, delivered by Cesarean delivery			1/4/XX - Present
Hypothermia in newborn			1/4/XX - Present

Non-Hospital Problems

None

Concurrent Nursing Documentation Newborns

Concurrent Nursing Documentation
DOHM Finalized (Mom and Baby): Yes
Newborn Hearing Rt Ear Results: Pass
Newborn Hearing Lt Ear Results: Pass
Hepatitis B Vaccine:: Refused
Cord Clamp Removed:: Yes
CCHD Results: Passed-Negative Screen

There is no immunization history on file for this patient.

Pertussis educational material presented to patients family concerning Pertussis vaccination availability. (Year-Round)
Pertussis Edu Material Presented : Yes
Influenza educational material presented to patients family concerning Influenza vaccination availability.(FLU season only)

Influenza Edu Material Presented : Yes

Antibiotics (Filter: URMC RX BROAD SPECTRUM ABX Medications Shown)

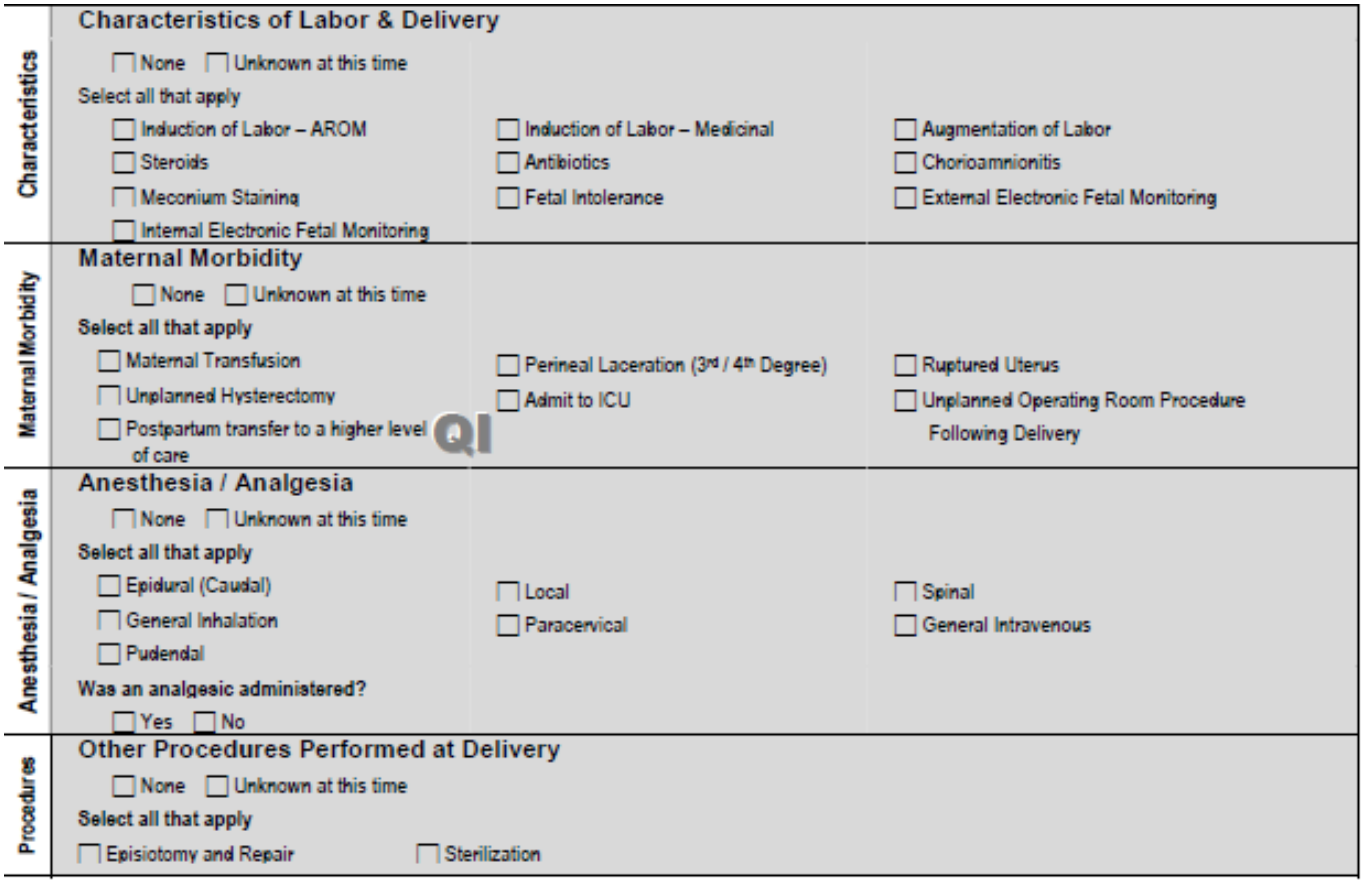
None

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
01/03/XX 1027	Admission	Inpatient	OBN	NBN	

Module 4 – L&D II

Extraction Exercise #1 - **Work Book Excerpts**



Characteristics

Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Induction of Labor – AROM	☐ Induction of Labor – Medicinal	☐ Augmentation of Labor
☐ Steroids	☐ Antibiotics	☐ Chorioamnionitis
☐ Meconium Staining	☐ Fetal Intolerance	☐ External Electronic Fetal Monitoring
☐ Internal Electronic Fetal Monitoring		

Maternal Morbidity

Maternal Morbidity

☐ None ☐ Unknown at this time

Select all that apply

☐ Maternal Transfusion	☐ Perineal Laceration (3rd / 4th Degree)	☐ Ruptured Uterus
☐ Unplanned Hysterectomy	☐ Admit to ICU	☐ Unplanned Operating Room Procedure Following Delivery
☐ Postpartum transfer to a higher level of care		

Anesthesia / Analgesia

Anesthesia / Analgesia

☐ None ☐ Unknown at this time

Select all that apply

☐ Epidural (Caudal)	☐ Local	☐ Spinal
☐ General Inhalation	☐ Paracervical	☐ General Intravenous
☐ Pudendal		

Was an analgesic administered?

☐ Yes ☐ No

Procedures

Other Procedures Performed at Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Episiotomy and Repair ☐ Sterilization

See Module 4 Answers section for correct responses.

Module 4 – L&D II

Extraction Exercise #1 - Work Book Answers

Characteristics of Labor and Delivery

_X_ None ___ Unknown at this time

Select all that apply

___ Induction of Labor–AROM ___ Induction of Labor-Medicinal ___ Steroids
___ Augmentation of Labor ___ Antibiotics ___ Meconium Staining
___ Chorioamnionitis ___ Fetal Intolerance
___ External Electronic Fetal Monitoring ___ Internal Electronic Fetal Monitoring

---

Maternal Morbidity

_X_ None ___Unknown at this time

Select all that apply

___Maternal transfusion ___Perineal Laceration (3rd/4th degree) ___Ruptured Uterus
___Unplanned Hysterectomy ___Admit to ICU
___Unplanned Operating Room Procedure Following Delivery
___Postpartum transfer to a higher level of care

Anesthesia / Analgesia

___None ___Unknown at this time

Select all that apply

___Epidural (Caudal) ___Loca l _X_Spinal ___General Inhalation ___Paracervical
___Pudendal ___General Intravenous

Was analgesia administered?

___Yes _X_No

Other Procedures Performed at Delivery

_X_None ___Unknown at this time

Select all that apply

___Episiotomy and Repair ___Sterilization

Module 4 – L&D II

Extraction Exercise #2

Below are abridged chart notes and an abridged example of a patient summary created for Birth Certificate Registrars. You will only be entering data for the second half of the L&D portion of the work book.

Fill in the appropriate answers on the Birth Certificate Work Book excerpts (last page).

Abridged Chart note 1 Attending Addendum (hosp. day 1):

- 25yo G1P0 @ 30w1d (by early ultrasound at U/S lab) who presents as a transfer from another hospital for concern for NRFHT and IUGR.
- Pregnancy complicated by maternal chronic hypertension (previously prescribed labetalol but not taking, mild range BPs), hepatitis C (patient unaware of this dx, documented in prenatal), and maternal CP (mild deficit at this time), Penicillin allergy.
- Reportedly had a normal anatomic ultrasound.
- FHR tracing on arrival with moderate variability and normal rate - rare variables but appropriate for gestational age. +FM. Vertex.
- Plan for official ultrasound for growth and fluid this morning - reflex to Dopplers.

Abridged Chart note 2 Social Work Information: Patient was tx to this hospital from another hospital for NRFHT and IUGR. Pt is currently 30w1d pregnant with her first baby, FOB has a 3 yo son. Patient stated that she has known FOB for 4 years but that they have only been dating for 1 year. Patient denies any IPV issues. FOB has a driver's permit; he is trying to secure a ride to this hospital today. Patient does not have a license. Pt indicated that she and FOB have some family support.
Pt has mild CP. Patient reports that her biggest symptom from her CP is muscle weakness. Pt feels that pregnancy has exacerbated this symptom. Patient currently has no specialist she sees for her CP and that this condition is managed by her PCP. Patient denies any drug use. Pt reports some anxiety re: baby's condition and being so far from home but reports a stable mood.
Discussed the availability of mental health consult after delivery. Pt is having a boy. Patient is uncertain about BC plan.
Impression: Pleasant woman who is hoping to have FOB arrive today as she would prefer not to be alone. Patient is concerned about her baby but feels she is coping well and able to manage her anxiety.
Plan: Provided pt with 7 gratis parking passes for FOB to facilitate visitation while she is hospitalized.
Patient denies any other SW needs at this time, she is aware of SW availability. Discussed with RN.
Signed: LMSW

Abridged Chart note 3 Attending Plan (hosp. day 2):

- BPP today 4/10, with AEDF and variable decelerations on monitoring.
- Discussed the etiologies and issues related to IUGR, and that both placental and fetal anomalies/genetics can result in IUGR. Discussed the options for testing, including amniocentesis for genetic and cholesterol/biochemical testing. However, also discussed that should this testing be declined, post-natal testing is also possible. Discussed pending the issues and etiology of the growth restriction- the range of possibilities and disabilities can include severe disability, including need for full time care for a lifetime.
- The patient is concerned about staying inpatient due to distance from family and concerns with long-term admission. Discussed the importance of assessment and following the baby closely, as there is a very high risk of IUFD.
- Discussed the need to be NPO for now, and the need for continuous monitoring and repeat BPP in the AM. Discussed NICU, and their role.
- Discussion with family and patient regarding multiple issues, including the possibility that the fetal weight could be lower, or higher than anticipated, and this could alter prognosis.
- Discussed that the interventions for her (including classical c/s) can increase the risk of complications with this c/s, as well as infertility and complications with future pregnancies. Discussed that the cesarean delivery could also increase the risk of future pregnancies, including infertility, abnormal placentation.
- Father of baby present for the conversation, is also planning to meet with NICU and discuss options as well.
- Both the patient and the FOB were born at 28 weeks.
- The FOB has a prior son with amniotic band, with multiple amputations- and discussed that this is not considered a recurrent or genetic disorder, and unlikely to be something that would recurrent.
- Given BMZ x1 at another hospital - will complete course with 2nd dose today.

- 24hr urine pending. GBS pending. Hep C testing pending to confirm diagnosis.
- Dispo pending ultrasound this morning.

Abridged Chart note 4 Attending Intrapartum (hosp. day2):

This is a 25 y.o. G1P0 at 30w3d who is admitted with non-reassuring fetal heart tracing as transfer from another hospital. Ultrasound showed EFW 14%ile with AC < 3%ile. UA Dopplers intermittently reversed yesterday with BPP 4/10. The patient has completed a betamethasone course. Tracing this morning with recurrent deep decelerations and periods of absent variability. Reviewed findings with the patient. Magnesium started for fetal neuroprotection. Will move towards delivery given lagging abdominal circumference, reverse UA Dopplers, BPP 4/10 and intermittently category III tracing. Discussed with NICU- potential for Smith-Lemli-Opitz given abnormal male genitalia on ultrasound. Anesthesia notified. Plan to proceed with primary cesarean section.

Abridged Birth Certificate Registrars' Summary

Dating Summary

Working EDD: 03/15/XX set by RN on 01/04/XX based on Patient Reported

Based On	EDD	GA Dif	GA	User	Date
Patient Reported	03/15/XX	Working		RN	01/04/XX

OB History

Gravida	Para	Term	Preterm	AB	TAB	SAB	Ectopic	Multiple	Living
1	1		1					0	1

#	Outcome	Date	GA	Labor/2nd	Weight	Sex	Delivery Anes	PTL	Living	Name	Location	Delivering Clinician
1	Preterm	01/XX	30w3d		1192 g (2 lb 10.1 oz)	M	CSLT SPINAL-	N	Y	BOY	Other	MD

Complications: Fetal Intolerance

OB Episode Encounters

Encounters related to Labor and Delivery Encounter on 1/4/XX with MD

Date	Encounter Type	Provider	Department	Reason
1/7/XX	Surgery	MD	OB	C-SECTION
1/7/XX	Procedure Pass	Not found	OB	Not found
1/7/XX	Anesthesia Event	MD	OB	Not found
1/7/XX	Anesthesia	MD	OB	Not found
1/7/XX	History	MD	OB	Not found
1/5/XX	History	MD	OB	Not found
1/4/XX	Labor and Delivery Encounter	MD	OB	Non-reassuring fetal heart rate or rhythm affecting mother,
1/4/XX	History	MD	OB	Not found

Hospital Problems

		Priority	Class	Noted - Resolved

Active Problems

Non-reassuring fetal heart rate or rhythm affecting mother	1/4/XX - Present

Non-Hospital Problems

None

Medical History

Past Medical History	Date	Comments
Hepatitis C carrier [B18.2]		
CP (cerebral palsy) [G80.9]		**mild or "spastic;" childhood LE braces, diplopia**
H/O varicella [Z86.19]		
Hypertension affecting pregnancy in second trimester [O16.2]	**10/XX**	

Surgical History

Past Surgical History	Laterality	Last Occurrence	Comments
Leg Tendon Surgery [SHX1004]	**Bilateral**		

Social History

Category	History
Smoking Tobacco Use	**Never Assessed**
Smokeless Tobacco Use	**Unknown**
Tobacco Comment	
Alcohol Use	**Not Asked**
Drug Use	**Not Asked**
Sexual Activity	**Not Asked**
ADL	**Not Asked**

Concurrent Nursing Documentation Maternal Information

ABO RH BLOOD TYPE

Date	Value	Ref Range	Status
01/07/XX	A RH POS		Final

HBV S AG

Date	Value	Ref Range	Status
01/04/XX	NEG		Final

Comment:
Test Method: CMIA

RUBELLA IGG AB

Date	Value	Ref Range	Status
08/10/XX	Immune		Final

HIV 1&2 ANTIGEN/ANTIBODY

Date	Value	Ref Range	Status
08/10/XX	Negative		Final

RAPID HIV 1&2

Date	Value	Ref Range	Status
01/04/XX	NEG		Final

Comment:
Test performed using Lateral Flow Immunoassay

Normal Value: Negative

SYPHILIS SCREEN

Date	Value	Ref Range	Status
01/04/XX	Neg		Final

Comment:
TEST METHOD: BioPLEX(Multiplex Flow Immunoassay)

GROUP B STREP CULTURE

Date	Value	Ref Range	Status
01/05/XX	.		Final

Facility-Administered Medications as of 1/10/XX

Medication	Dose	Frequency	Last Dose
• [COMPLETED] clindamycin (CLEOCIN) IVPB 900 mg	900 mg	Daily	900 mg at 01/07/XX 0957
And			
• [COMPLETED] gentamicin (GARAMYCIN) 40 MG/ML 515.2 mg in sodium chloride 0.9 % 110 mL IVPB	5 mg/kg	Once	515.2 mg at 01/07/XX 1040
• [COMPLETED] clindamycin (CLEOCIN) 900 MG/50ML IVPB			0 mg at 01/07/XX 1000

Chromosome Analysis

**** No results found for the last 7440 hours. ****

Weights (since admission)

Date/Time	Height	Weight	PrePregnancy Weight	Pregnancy weight change (kg)	BMI (Calculated)	BSA (Calculated - sq m)	Who
01/04/XX 2119	1.651 m (5' 5")	103 kg (227 lb)	--	--	37.9	2.? sq meters	JC

Steroidal Medications

As of 01/10/XX 1220

betamethasone acetate & sodium phosphate (CELESTONE) injection 12 mg (mg)

Total dose: **12 mg**

Dose	Action	Route	Admin Date/Time	Admin User
12 mg	**Given**	**Intramuscular**	**01/05/XX ?38**	**RN**

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
01/04/XX 2054	Admission	Observation	OB	OB	
01/07/XX 0945	Surgery	Inpatient	OB		OBGYN
01/07/XX 1029	Patient Update	Observation	OB	OB	
01/07/XX 1033	Patient Update	Inpatient	OB	OB	

Boy []

Delivery Information

Boy Sex: male Gestational Age: 30w3d MRN:_____ **PCP:** MD
Delivery Date/Time: 1/7/XX
Time of Head Delivery: 1/7/XX 10:23 AM
Delivery Type: C-Sec, Low Transverse Meconium at time of delivery: none
Delivery Location: OR

Labor Onset Date/Time: Dilation Complete Date/Time:
Preterm labor: No **Antenatal steroids:** Full Course **Antibiotics received during labor:** No
First Cervical ripening date/time: / **Cervical ripening Type:**
Rupture Date: 1/7/XX **Rupture Time:** 10:22 AM **Details: Rupture Type:** Artificial **Color:** Clear **Amount:** Moderate
Induction:
Indications: Augmentation: .None
Labor complications: Fetal Intolerance

@OBDELIVERYPROVIDERS@**Anesthesia Method:** Spinal- **Analgesics:**
Presentation: Vertex **Position:**
Prophylactic Maneuver: No

Shoulder Dystocia: No
Resuscitation: Dry;Tactile Stimulation;Bulb Suctioning;Oxygen;PPV
Living Status: Yes

APGARs	Total	Color	Reflex irritability	Breath	Heart Rate	Muscle Tone	Assigned By (greater than 7 no need for next measurement)
1 min	6	1	1	1	2	1	NICU
5 min	8	1	2	2	2	1	NICU
10 min							
15 min							
20 min							
25 min							
30 min							

Birth Weight: Height: Head Circumference: Observed Anomalies:
Cord: 3 Vessels Complications: NONE Clamping Delayed: 0 Clamped Date/Time:1/7 10:23 AM Cord blood disposition: Lab Gases sent: Yes Stem cell collection -by MD-: No
Maternal Info:
Placenta Delivery Date/Time: 1/7 10:25 AM Removal: C-Section Removal Appearance: Abnormal Disposition: pathology
Bonding:
Stages of Labor: Stage One: h m Stage Two: 0h 0m Stage Three: 0h 2m
Episiotomy: None
Perineal lacerations:
Delivery est. blood loss (mL):
Procedures: None

***Labor Events**

Preterm labor?: No
Rupture date: 1/7/XX
Rupture type: Artificial
Rupture Time: 10:22 AM
Induction: .None
Augmentation: .None

Hospital Problems

	Priority	Class	Noted - Resolved
Active Problems			
Preterm newborn, gestational age 30 and 3/7 weeks			1/7/XX - Present
Prematurity			1/7/XX - Present
Neonatal hypoglycemia			1/7/XX - Present
Hypospadias			1/7/XX - Present
Transient neonatal thrombocytopenia			1/7/XX - Present
Hyperbilirubinemia of prematurity			1/9/XX - Present
Resolved Problems			
RESOLVED: Respiratory distress syndrome in newborn			1/7/XX - 1/9/XX
RESOLVED: Need for observation and evaluation of newborn for sepsis			1/7/XX - 1/9/XX

Non-Hospital Problems

None

Concurrent Nursing Documentation Newborns

Concurrent Nursing Documentation
NYS NB Screen Number:: ___ ___ ___

There is no immunization history on file for this patient.

Antibiotics (Filter: URMC RX BROAD SPECTRUM ABX Medications Shown)

None

Events

Date/Time	Event	Pt Class	Unit	Room/Bed	Service
01/07/XX 1023	Admission	Inpatient	NICU	NICU	
01/07/XX 1130	Transfer Out	Inpatient	NICU	NICU	
01/07/XX 1130	Transfer In	Inpatient	NICU	NICU	

Module 4 - L&D II

Extraction Exercise #2 Work Book Excerpts

Please, enter the correct information

Characteristics

Characteristics of Labor & Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Induction of Labor – AROM	☐ Induction of Labor – Medicinal	☐ Augmentation of Labor
☐ Steroids	☐ Antibiotics	☐ Chorioamnionitis
☐ Meconium Staining	☐ Fetal Intolerance	☐ External Electronic Fetal Monitoring
☐ Internal Electronic Fetal Monitoring		

Maternal Morbidity

Maternal Morbidity

☐ None ☐ Unknown at this time

Select all that apply

☐ Maternal Transfusion	☐ Perineal Laceration (3rd / 4th Degree)	☐ Ruptured Uterus
☐ Unplanned Hysterectomy	☐ Admit to ICU	☐ Unplanned Operating Room Procedure Following Delivery
☐ Postpartum transfer to a higher level of care		

Anesthesia / Analgesia

Anesthesia / Analgesia

☐ None ☐ Unknown at this time

Select all that apply

☐ Epidural (Caudal)	☐ Local	☐ Spinal
☐ General Inhalation	☐ Paracervical	☐ General Intravenous
☐ Pudendal		

Was an analgesic administered?

☐ Yes ☐ No

Procedures

Other Procedures Performed at Delivery

☐ None ☐ Unknown at this time

Select all that apply

☐ Episiotomy and Repair ☐ Sterilization

See next page for answers

Module 4 L&D II

Extraction Exercise #2 Answers

Characteristics of Labor and Delivery

___ None ___ Unknown at this time

Select all that apply

___ Induction of Labor–AROM ___ Induction of Labor-Medicinal _X_ Steroids

___ Augmentation of Labor ___ Antibiotics ___ Meconium Staining

___ Chorioamnionitis _X_ Fetal Intolerance

_X_ External Electronic Fetal Monitoring ___ Internal Electronic Fetal Monitoring

---

Maternal Morbidity

_X_ None ___ Unknown at this time

Select all that apply

___Maternal transfusion ___Perineal Laceration (3rd/4th degree) ___Ruptured Uterus

___Unplanned Hysterectomy ___Admit to ICU

___Unplanned Operating Room Procedure Following Delivery

___Postpartum transfer to a higher level of care

Anesthesia / Analgesia

___None ___Unknown at this time

Select all that apply

___Epidural (Caudal) ___Local _X_ Spinal ___General Inhalation ___Paracervical

___Pudendal ___General Intravenous

Was analgesia administered?

___Yes _X_ No

Other Procedures Performed at Delivery

_X_None ___Unknown at this time

Select all that apply

___Episiotomy and Repair ___Sterilization

Things to remember:

- When looking for "Antibiotics" you may have to look at the time given and the delivery time to see if they were given antepartum. Only antibiotics administered in the laboring periods are documented.
- This woman has a Penicillin allergy.

Scenario Exercise(s)

Module 4 – L&D II

Scenario Exercises

Enter the correct information

Exercise #1

Following the delivery the woman had a tubal ligation. She did not have any analgesia or anesthetic for the labor and delivery, just spinal anesthesia for the tubal.

Anesthesia / Analgesia

___None ___Unknown at this time

Select all that apply

___Epidural (Caudal) ___Local ___Spinal ___General Inhalation ___Paracervical

___Pudendal ___General Intravenous

Was analgesia administered? ___Yes ___No

Other Procedures Performed at Delivery

___None ___Unknown at this time

Select all that apply

___Yes ___No

___Episiotomy and Repair ___Sterilization

Exercise #2

A woman enters the hospital in labor. She receives an epidural when 5 cm. dilated and is placed on continuous EFM. After 18 hr., she was fully dilated and began pushing. After pushing for 2 ½ hours without being able to deliver the baby, the baby begins to experience increasingly severe decelerations. The decision was made to move toward C-section ASAP. General anesthesia was administered.

Onset of Labor

___ None ___ Unknown at this time

Select all that apply

___ Prolonged ROM (12 or more hrs.) ___ Premature ROM (before onset of labor)

___ Precipitous labor (less than 3 hrs.) ___ Prolonged labor (20 or more hrs.)

Characteristics of Labor and Delivery

Select all that apply

___ Induction of Labor–AROM ___ Induction of Labor-Medicinal ___ Steroids

___ Augmentation of Labor ___ Antibiotics ___ Meconium Staining

___ Chorioamnionitis ___ Fetal Intolerance

___ External Electronic Fetal Monitoring ___ Internal Electronic Fetal Monitoring

Anesthesia / Analgesia

Select all that apply

___Epidural (Caudal) ___Local ___Spinal ___General Inhalation ___Paracervical

___Pudendal ___General Intravenous

Was analgesia administered?

___Yes ___No

Scenario #3

On arriving at the hospital at 1900 hr. the woman said her waters broke at 1700 hr. At 2030 hr. with irregular Contractions but no real cervical change the MD ordered Pitocin and continuous EFM.

Characteristics of Labor and Delivery

Select all that apply

___ Induction of Labor–AROM	___ Induction of Labor-Medicinal	___ Steroids
___ Augmentation of Labor	___ Antibiotics	___ Meconium Staining
___ Chorioamnionitis	___ Fetal Intolerance	
___ External Electronic Fetal Monitoring	___ Internal Electronic Fetal Monitoring	

See next page for answers

Module 4 – L&D II

Scenario Exercises Answers

Exercise #1

Following the delivery the woman had a tubal ligation. She did not have any analgesia or anesthetic for the labor and delivery, just spinal anesthesia for the tubal.

Anesthesia / Analgesia

_X_None ___Unknown at this time

Select all that apply

___Epidural (Caudal) ___Local ___Spinal ___General Inhalation ___Paracervical

___Pudendal ___General Intravenous

Was analgesia administered? ___ Yes _X_ No

Other Procedures Performed at Delivery

___None ___Unknown at this time

Select all that apply

___Yes ___No

___ Episiotomy and Repair _X_ Sterilization

The objective of this item is to collect information on mothers who receive anesthesia to control pain during the LABOR process only, so any anesthesia administered during recovery or at any time post-delivery would not be reportable for this 'Analgesia/Anesthesia' use. (NCHS, (National Center for Health Statistics) (Slide 13

Exercise #2

A woman enters the hospital in labor. She receives an epidural when 5 cm. dilated and is placed on continuous EFM. After 18 hr., she was fully dilated and began pushing. After pushing for 2 ½ hours without being able to deliver the baby, the baby begins to experience increasingly severe decelerations. The decision was made to move toward C-section ASAP. General anesthesia was administered.

Onset of Labor

___ None ___ Unknown at this time

Select all that apply

___ Prolonged ROM (12 or more hrs.) ___ Premature ROM (before onset of labor)

___ Precipitous labor (less than 3 hrs.) _X_ Prolonged labor (20 or more hrs.)

Characteristics of Labor and Delivery

Select all that apply

___ Induction of Labor–AROM ___ Induction of Labor-Medicinal ___ Steroids

___ Augmentation of Labor ___ Antibiotics ___ Meconium Staining

___ Chorioamnionitis _X_ Fetal Intolerance

_X_ External Electronic Fetal Monitoring ___ Internal Electronic Fetal Monitoring

Anesthesia / Analgesia

Select all that apply

_X_ Epidural (Caudal) ___Local ___Spinal _X_ General Inhalation ___Paracervical

___Pudendal _X_ General Intravenous

Was analgesia administered?

___Yes _X_ No

Time spent pushing is still considered labor. Therefore, 18hr. + 2 ½ hrs. = 20 ½ hrs.

"General Anesthesia" is almost always "General Intravenous" followed by "General Inhalation". Select both.

Scenario #3

On arriving at the hospital at 1900 hr. the woman said her waters broke at 1700 hr. At 2030 hr. with irregular Contractions but no real cervical change the MD ordered Pitocin and continuous EFM.

Characteristics of Labor and Delivery

Select all that apply

___ Induction of Labor–AROM	_**X**_ Induction of Labor-Medicinal	___ Steroids
___ Augmentation of Labor	___ Antibiotics	___ Meconium Staining
___ Chorioamnionitis	___ Fetal Intolerance	
_**X**_ External Electronic Fetal Monitoring	___ Internal Electronic Fetal Monitoring	

"No real cervical change" implies that the woman is not in labor; therefore, starting Pitocin is induction.

Module Evaluation

Registrar Name:_____Hospital: _____Date:_____(MM/DD/YY)

MODULE FOUR EVALUATION

(Please mark the appropriate response)

1. **If, upon admission to L&D, the physician ruptures the amniotic sac to induce labor but labor does not begin until Pitocin is given, what would you enter in the *Characteristics of Labor & Delivery* field?**
    - Induction of Labor- Medicinal
    - Induction of Labor- AROM
    - Induction both Medicinal and AROM

2. **The physician ruptures a pregnant woman's membranes when she is 8cm dilated. This would always be considered augmentation of labor.**
    - True
    - False

3. **Terminal meconium would not be entered in the *Characteristics of Labor & Delivery* section of the birth certificate.**
    - True
    - False

4. **If a mother doesn't have a tubal ligation until the day after she delivers, "Sterilization" would not be entered in the *Other Procedures Performed at Delivery* field.**
    - True
    - False

5. **If during labor membranes are artificially ruptured (AROM) so an IUPC can be inserted the following would be entered:**
    - Induction of Labor
    - Augmentation of Labor
    - Internal Electronic Fetal Monitoring
    - None of the above

6. **If a 2nd degree laceration is repaired following delivery you would enter:**
    - Episiotomy and Repair
    - Perineal Laceration
    - Neither of the above

7. **If a woman is given an epidural containing fentanyl but receives no other analgesics during labor, *Analgesia* would be entered as 'No'.**
    - True
    - False

Registrar Name:_____Hospital: _____Date:_____(MM/DD/YY)

8. **A pregnant woman who was 3 cm dilated when she saw her physician last week is admitted to the hospital without contractions at 4 cm dilation. She is given Pitocin soon after admission. What would you enter in the *Characteristics of Labor & Delivery* field, induction or augmentation?**
    - Induction of Labor- Medicinal
    - Augmentation of Labor

9. **If Tylenol is given to a woman who had a headache during labor this would be entered as *Analgesic*='Yes'.**
    - True
    - False

10. **If general inhalation *Anesthesia* is used during the delivery, general intravenous anesthesia will also almost always be used.**
    - True
    - False

See next page for answers

MODULE FOUR EVALUATION *ANSWERS*

1. **If, upon admission to L&D, the physician ruptures the amniotic sac to induce labor but labor does not begin until Pitocin is given, what would you enter in the *Characteristics of Labor & Delivery* field?**
    - Induction of Labor- Medicinal
    - Induction of Labor- AROM
    - Induction both Medicinal and AROM

   Answer: Without the start of labor (no cervical change) following AROM, adding oxytocin would be entered as induction. (Slide 5)

2. **The physician ruptures a pregnant woman's membranes when she is 8cm dilated. This would always be considered augmentation of labor.**
    - True
    - False

   Answer: AROM may be done for many reasons other than augmentation (Slide 6)

3. **Terminal meconium would not be entered in the *Characteristics of Labor & Delivery* section of the birth certificate.**
    - True
    - False

   Answer: All types of meconium (including terminal meconium) should be entered as "Meconium Staining". (Slide 9)

4. **If a mother doesn't have a tubal ligation until the day after she delivers, "Sterilization" would not be entered in the *Other Procedures Performed at Delivery* field.**
    - True
    - False

   Answer: Sterilization that occurs at anytime during the birth hospitalization should be entered. (Slide 15)

5. **If during labor membranes are artificially ruptured (AROM) so an IUPC can be inserted the following would be entered:**
    - Induction of Labor
    - Augmentation of Labor
    - Internal Electronic Fetal Monitoring
    - None of the above

   Answer: AROM is done for many reasons other than induction/augmentation of labor including insertion of pressure catheter (IUPC). An IUPC is not an internal fetal monitor but can be used with one. (Slides 6 & 10)

6. **If a 2nd degree laceration is repaired following delivery you would enter:**
    - Episiotomy and Repair
    - Perineal Laceration
    - Neither of the above

   Answer: Only 3rd & 4th degree Perineal Lacerations are entered in the Maternal Morbidity section of the birth certificate. (Slide 11) Episiotomy and Repair is entered only when an episiotomy is performed (Slide 15)

7. **If a woman is given an epidural containing fentanyl but receives no other analgesics during labor, *Analgesia* would be entered as 'No'.**
    - True
    - False

    Answer: Fentanyl is an analgesic and all analgesics are entered in the Analgesia section of the birth certificate even when given as part of the anesthesia. (Slide 14)

8. **A pregnant woman who was 3 cm dilated when she saw her physician last week is admitted to the hospital without contractions at 4 cm dilation. She is given Pitocin soon after admission. What would you enter in the *Characteristics of Labor & Delivery* field, induction or augmentation?**
    - Induction of Labor- Medicinal
    - Augmentation of Labor

    Answer: If a woman not in labor and is given Pitocin to get labor started induction of Labor- Medicinal would be entered. (Slide 4)

8. **If Tylenol is given to a woman who had a headache during labor this would be entered as *Analgesic*='Yes'.**
    - True
    - False

    Answer: Any analgesic (narcotic or non-narcotic) used during labor and delivery is coded in the Analgesia section of the birth certificate. (Slide 14)

10. **If general inhalation *Anesthesia* is used during the delivery, general intravenous anesthesia will also almost always be used.**
    - True
    - False

Answer: General inhalation anesthesia will almost always be preceded by general intravenous anesthesia. (Slide 13)

Extra Information

Module 4
INDUCTION VS. AUGMENTATION

1. **Intent is key**
   Induction: If a woman not in labor is admitted for the purpose of getting labor started, it is an induction, whether the means is oxytocin, prostaglandin, AROM, laminaria, "EASI", jumping jacks, or some combination of these.
   Augmentation is when someone in dysfunctional labor (i.e. already in some semblance of labor – generally spontaneous in onset- but inadequate for normal progress) is given additional help to get the process going, usually either with Oxytocin or AROM.

2. If a woman is induced it would be rare that she should also be coded as being augmented (i.e., if you are unsure, induction trumps augmentation).
   The main exception would be an AROM induction in which contractions ensue but not enough for adequate for adequate labor.* If the cervix has changed at least somewhat, use of Oxytocin under this circumstance would be augmentation.
   Without any cervical change following AROM, adding oxytocin would be better coded as an agent of induction, even though AROM was the initial effort. Following initial use of oxytocin for induction, subsequent AROM does not constitute augmentation.

3. Whether or not cervical ripening is used, if oxytocin is the initial agent, the Induction should be coded as medicinal, even if AROM is performed later. If AROM is performed first but does nothing and oxytocin subsequently is added, they both may be listed as induction agents (i.e… select both medicinal and AROM in the induction fields)

   - Bear in mind that AROM may be done for many reasons, only one of which is augmentation or induction. Other reasons include facilitating placement of a scalp electrode, to check for meconium, to allow the head to descend, and because it's going to happen eventually anyway (i.e., just because) Often an obstetrician's threshold for rupturing membranes is low and minor deviations in / from the labor curve will lead to AROM even though the labor pattern may not have been dysfunctional per se.

   *I suppose on could substitute "prostaglandin" or "EASI" for AROM, in cases in which a woman starts to labor (albeit eventually dysfunctional) after cervical ripening but before the intended agent of induction is begun

Glantz
2005

AROM (Artificial Rupture of Membranes)

When AROM (artificial rupture of membranes) is not coded as induction or augmentation

- **Augmentation by AROM** – the woman is in labor with a long active phase.
- Just to get the membranes out of the way if there was no SROM (spontaneous ROM).
- **Rupturing the FOREWATER** – *this is not an AROM* as it is just a small pocket of fluid that has become trapped by the already ruptured membranes.
- **AROM of a pt. who is eminently delivering or delivers "en caul" (baby delivers within the membranes).** The AROM is simply done to get the baby out of the membranes.
- **AROM for fetal assessment** – placement of a fetal scalp electrode or an IUPC (intrauterine pressure catheter) through the membrane thus rupturing them is not coded as augmentation
- **AROM during a C-section** – This is neither augmentation nor induction.