Vaginal Birth

VB1

Woman's Initials	Place of Birth	Gravida/Parity	Gestation
CJ	Location of the birth	G P	Gestation in weeks & days ie 35.2w

Maternal History ***TIP****: history and current information can be located in the woman's handheld record*

Past Pregnancy Information	
Gravida & Parity Also Include: • Date • Place • Gestation in weeks • Labour, birth and postnatal details • Birth weight • Gender • Feeding type and duration and baby's name	
Medical/Surgical	
Enter all past medical history including: • Deep vein thrombosis • Diabetes • Epilepsy • Gynaecological problems • Gastrointestinal disorders • Heart disease • High Blood Pressure • Kidney disease • Asthma/respiratory disease	• Thyroid disorders • Previous anaesthetic problems • Dental health and jaw problems • Back problems • Blood transfusion • Alcohol intake (include standard drinks per day) • Smoking (include number per day) • Illicit drug use • Other Enter all previous surgery and complications
Family History	
Enter all family history and prenatal diagnostic issues (include maternal and paternal) Include: • Diabetes • Heart disease • High blood pressure • Genetic disorders/congenital/developmental abnormalities • Mental health concerns	
Psychosocial (include ANRQ/EPDS)	
Record any psycho/social issues, including: • Mental health history • Anxiety/depression • Postnatal depression (PND) • Psychiatric disorders • Major stressors, life changes or losses • Relationship issues • Contact with Families SA • Accommodation issues • Employment/financial issues • other	
Medications	
Record all medication history, include: • Medication • Dose • Frequency • When ceased or if current	
Allergies	
Record all allergies and adverse drug reactions, include (if relevant): • Medicine (or other) • Reaction type	
Antenatal history/complications	
Record any complications in current pregnancy history: • Admissions (reason, treatment & outcomes) • Complications (description, treatment & outcomes)	

Investigations and diagnostics

	Date	Findings/ Implications
Blood group	(record the date that the investigation or diagnostic occurred)	Record blood group and management eg for AntiD
CBP		Record levels and significance/management (if any)
HB		Record Hb at booking and at 28/40
Antibodies		• Record antibodies (positive or negative) • If positive- state, the name of the antibody (this is relevant to the newborn management at birth)
GBS		Record results here (urine, low vaginal swab [LVS], other, declined)
Ultrasound results		Record date of morphology scan and findings, include implications if findings have significance. List all other ultrasounds performed here if more than one is performed (eg. rescan 32 weeks for low lying placenta; note proximity to internal os)
Placental location		Record placental site location (anterior/posterior)
Serology		Record serology results and implications. Hep B & C, HIV, Syphilis, Rubella, vitamin D eg if Hep B positive, referrals and management issues.
other		• MSSU • Pap smear • First trimester (combination) chromosomal screening • Second trimester chromosomal screening • Neural tube defect (NTD) • Non-invasive prenatal testing (NIPT)

Birth Plan:

Record the woman's wishes for her birth including:

- support people that she wishes to attend
- birth wishes (active, pain management including natural therapies, music, water, hypnobirthing, epidural; skin to skin, vitamin K, Hep B, cultural needs)

Labour:

Spontaneous	Induced	Augmented
Indicate here if the labour started spontaneously and date and time	Indicate here if the labour was induced (Induction balloon catheter/ Prostaglandin/ARM/oxytocin infusion) Provide rationale, woman's consent and method(s) used	Indicate here if labour was augmented (ARM/oxytocin infusion). Provide rationale, woman's consent and method(s) used

Membranes

Enter type of ROM - SROM/PROM/PPROM etc
Indicate ROM/PROM and date and time of ROM
Liquor colour
• Record liquor colour eg clear, pink, blood stained, MSL, thin MSL • Record odour (if present: offensive/nil)

Fetal Monitoring

- Record type and rationale/ indication for monitoring. If a CTG, provide interpretation of the CTG trace
- Fetal scalp pH/lactate - time and values

Pain Management in Labour
Record pain management methods, include:

- breathing through contractions,
- massage
- positioning
- shower
- movement
- rocking
- nitrous oxide
- Fentanyl (include route: S/C, intranasal, I/V)
- Epidural (Bolus/PCEA)
- Spinal
- Other

Pharmacological or non-pharmacological. Ensure you describe the **effectiveness**

Birth details
Ensure these details match what is documented in the woman's clinical records.

	Date	Time
Admission to birth unit		
Membranes ruptured		
Labour commenced		
Second stage commenced		
Time of birth		
Third stage completed		

Total Labour Duration

	Duration
First Stage	
Second stage	
Third stage	
	Total:

Ensure this is listed in hours and minutes.

Third stage of labour

Record whether active or physiological, include use of oxytocics, dose, route, manual removal, controlled cord traction (CCT).

Describe the placenta and list the weight (if recorded), indicate if the placenta was sent to histopathology

Describe the membranes (including cord insertion, vessel numbers and completeness of membranes)

Perineum

Describe the woman's perineum including the presence of trauma and management.

Include if relevant:

- tears describe type (1st, 2nd, 3a, 3b, 3c, 4th)
- episiotomy type (right mediolateral, midline, left mediolateral)
- grazes (describe location and management)
- labial trauma (describe trauma and management)
- Include perineal repair details including where relevant anaesthetic details (type and mls), suture materials used, description of repair and education provided
- If 3rd or 4th degree, state where the repair took place

Urinary Catheter
Record any indication for an IDC. For example, IDC inserted as EDB in situ.

Neonate

Sex	Alive/ stillborn/ neonatal death
Male/ Female/ undetermined	Record neonate's status
Weight	**Length**
In grams	In cms
Head Circumference	**Skin-to-skin (comment if not)**
In cms	Discuss when skin to skin occurred For how long Provided reason if did not occur
Breastfeeding (please comment on establishment of breastfeeding time i.e 5 minutes)	**Cord gas values**
Comment on when breastfeeding was established and if not provide rationale	State the values and indication for the cord gases to be taken
Neonatal resus performed	**1-hour BGL**
State the methods (suction, Neopuff, bag and mask, intubation, cardiac compressions)	State not appliable if no taken If required state justification with the value

APGARs

	1 min	5 min	10 min
Colour			
Heart Rate			
Reflexes			
Muscle Tone			
Respiration			
	total	total	total

Was the midwifery student the primary accoucher at this birth? *

- ☐ By ticking this box, I (the student) confirm that I was the primary accoucher at this birth
- ☐ By ticking this box, I (the Clinician) acknowledge that the midwifery student was the primary accoucher for this birth

***TIP**. Both boxes must be ticked for you to count as the accoucheur of the birth. Ask your supervising midwife if they agree that you were the accoucheur of the birth and ask if it's ok for you to tick the confirmation box before you pass over your device for a signature.*

Signature and designation of the supervising midwife or doctor. Date of signature and date of the episode of care must match *(retrospectively signed records will not be counted).*