

**SPECIFIC SCREENS FOR 5% QUALITY SAMPLE
MATERNITY ADMISSIONS FOR DELIVERY**

Specific quality screen	Checklist
<p>M1. Is there evidence that the admission assessment for delivery was completed according to acceptable standards of practice?</p>	<p>M1.1 Chart included prenatal record (if prenatal care given) or history and physical with detailed obstetrical history.</p> <p>M1.2 Required labwork was completed during pregnancy or upon admission and results documented in the record. ACOG suggested lab work:</p> <ul style="list-style-type: none"> • Hematocrit or hemoglobin levels • Urinalysis, including microscopic examination • Urine testing to detect asymptomatic bacteriuria • Determination of blood group and CDE (Rh) type • Antibody screen • Determination of immunity to rubella virus • Syphilis screen • Cervical cytology (as needed) • Hepatitis B virus surface antigen • Human immunodeficiency virus antibody testing <p>M1.3 Documented initial nursing assessment included: maternal vital signs, fetal heart tones, contraction frequency and duration, cervical dilatation and effacement (unless contraindicated as in placenta previa).</p> <p>M1.4 Physician was notified of patient admission within one hour of presentation (earlier if high risk patient)</p> <p>M1.5 High risk factors were identified and adequately addressed. (See PHRM/ISS Maternity Risk Screening)</p> <p>M1.6 Nursery/NICU notified if high risk mother/infant identified during assessment.</p>

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<p>M2. Is there evidence that monitoring of maternal and fetal status was provided during labor according to acceptable standards of practice?</p>	<p>M2.1 Maternal status was monitored evidenced by vital signs documented every 4 hours at a minimum and maternal pelvic exam (if applicable) documentation. M2.2 Fetal heart monitoring occurred every 30 minutes during first stage (defined as when active labor begins) and every 15 minutes during second stage. (2nd stage begins when cervical dilatation is complete). M2.3 Nonreassuring findings were communicated to physician. M2.4 Documentation of monitoring of fetal heart rate and uterine activity before and after any pain medication is provided. M2.5 When pitocin is being used, there is documentation of monitoring of fetal heart rate and uterine activity before all dosage changes.</p>
<p>M3. Before induction of labor or Cesarean delivery, is there evidence provided for a non-emergency delivery of fetal maturity > 39 weeks gestation (AGOG guideline)?</p>	<p>ACOG suggests fetal maturity may be assumed if one of the following criteria is met. M3.1 Fetal heart tones have been documented for 20 weeks by fetoscope or 30 weeks by Doppler. M3.2 36 weeks have elapsed since positive results were obtained from serum or urine HCG test. M3.3 Ultrasound measurement of crown-rump length obtained at 6-11 weeks gestation supports a current gestation age of 39 weeks. M3.4 Clinical history and physical and ultrasound exams performed at 12-20 weeks of gestation support a current gestational age of 39 or more weeks. M3.5 Fetal lung maturity proven by amniocentesis.</p>
<p>M4. Is there evidence that Cesarean delivery was completed within standard time frames once fetal distress identified?</p>	<p>M4.1 There is documented evidence that time from decision to incision is 30 minutes or less.</p>
<p>M5. Is there evidence that Vaginal Birth after Cesarean Delivery has continual monitoring of fetal heart rate and contractions during labor?</p>	<p>M5.1 Documentation of continuous fetal monitoring and continuous monitoring of contractions during labor of VBAC patient.</p>
<p>M6. Is there evidence that all complications were adequately addressed?</p>	<p>M6.1 Documentation to indicate that any unusual or abnormal outcomes were addressed appropriately.</p>

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M7. Is there evidence that patient's pain management requests were addressed according to acceptable standards of practice?	<p>M7.1 Documentation that patient's pain levels were regularly assessed.</p> <p>M7.2 Documentation that patient's requests for pain medication were provided in a safe, appropriate manner.</p> <p>M7.3 Documentation that choice of analgesia/anesthetic offered to patient. (Epidural should be available regardless of finances if not medically contraindicated)</p>
M8. Is there evidence of adequate staff present for delivery?	<p>M8.1 Physician/nurse midwife was present for delivery.</p> <p>M8.2 Evidence that required personnel, including nurses, anesthesia personnel, neonatal resuscitation team members and obstetric attendants are readily available.</p>
M9. Is there evidence of appropriate monitoring and interventions for abnormalities immediately following delivery?	<p>M9.1 Maternal assessment/intervention immediately after birth and repeated every 15 minutes for one hour and more frequently if complications arise. (ACOG standard). Assessment should include at a minimum:</p> <ul style="list-style-type: none"> • Blood pressure, temperature, respirations, pulse • Amount of vaginal bleeding • Uterine fundus massage and size • Degree of uterine contraction • Medication (analgesia and anesthesia)
M10. Is there evidence that regular postpartum assessments were completed?	<p>M10.1 The following maternal assessment was completed at least every shift:</p> <ul style="list-style-type: none"> • Breasts (engorgement, nipples intact) • Uterus (tone, position, size) • Cesarean delivery incision (dressing, drainage) • Bladder (voiding pattern, distention) • Bowel (movements, hemorrhoids) • Lochia (type, amt, color, clots) • Perineum (episiotomy, infection) • Legs for thrombophlebitis (Homan's sign, redness, tenderness, warmth) • Pain • Vital signs

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<p>M11. Is there evidence that patient was provided adequate discharge instructions?</p>	<p>M11.1 Patient was provided self-care instructions. M11.2 Patient was provided education in care of newborn. M11.3 Documentation of follow-up appointment with provider. M11.4 Documentation that patient was provided adequate referral resources for self and newborn. (i.e. WIC, Health Department, emergency phone numbers, breastfeeding support referral).</p>