This fourth part of the internal audit tool is used to evaluate the individual medical records for evidence of appropriate clinical processes that control risk in the maternity services. This section is divided up into three main areas addressing antenatal, intrapartum and postnatal care. There is also a section addressing management of post-partum haemorrhage for patients file.

Please complete the patient identification and in the results section indicate yes, no or not applicable as appropriate to the question.

Maternal UR Number/ID: **Neonatal UR/ID:**

Antenatal care

#	Antenatal care criterion	Result	Comment
First antenatal assessment			
71	Date of first visit documented (Y/N)		
72	Interpreter required documented (Y/N)		
73	Age at first visit documented (Y/N)		
74	Estimated due date (EDD) documented (Y/N)		
75	Method of EDD estimation documented (Y/N)		
76	Gestational age at first visit documented (Y/N)		
77	First visit occurred before 12 weeks gestation? (Y/N)		
78	Medical history documented (Y/N)		
79	Family history documented (Y/N)		
80	Social history documented(Y/N)		
81	Mental health history documented (Y/N)		
82	Smoking history documented (Y/N)		
83	Alcohol history documented (Y/N)		
84	Drug history documented (Y/N)		
85	Nutritional supplements history documented (e.g. folic acid, , vitamins) (Y/N)		
86	Pap smear history documented (Y/N)		

#	Antenatal care criterion	Result	Comment
87	BP documented (6) (Y/N)		
88	Proteinuria tested and documented (6) (Y/N)		
89	BMI calculated and documented (Y/N)		
90	Maternal risk factors identified and documented? (Y/N)		
91	Model of care documented? (Y/N)		
92	Appropriateness for model of care (with consideration of risk factors) (Y/N/unable to determine)		
Initial antenatal screening (at first and/or second visit)			
93	Blood group and rhesus D status (Y/N)		
94	Full Blood examination undertaken (Y/N)		
95	Syhillis screening undertaken (Y/N)		
96	Hep B screening undertaken (Y/N)		
97	Hep C screening undertaken (5) (Y/N)		
98	Rubella Screening undertaken (Y/N)		
99	HIV screening undertaken (6) (Y/N)		
100	Mid stream urine (MSU) for bacteriuria undertaken (Y/N)		
101	Maternal serum screen (MSS) in first trimester undertaken (Y/N)		
102	USS before 14/40 undertaken (Y/N)		
Subsequent antenatal visits			
103	Blood Pressure documented at every visit (Y/N)		
104	Urinalysis is documented (if indicated by hypertension) (7) (Y/N/NA)		
105	Fetal movement assessment every visit is documented (Y/N)		
106	Symphysis-fundal height (SFH) assessed at every visit after 20/40 is documented (Y/N)		
107	Abdominal palpation assessed at every visit after 30/40 is documented (Y/N)		

#	Antenatal care criterion	Result	Comment
Subsequent screening tests			
108	Glucose Challenge test undertaken (Y/N)		
109	Ultrasound 18-20 weeks undertaken (Y/N)		
110	Group B streptococcus (GBS) undertaken if universal approach to screening at service or if woman high risk (Y/N/NA)		
111	FBE at 28 weeks undertaken (Y/N)		
112	Syphilis, Hepatitis B, Hepatitis C, HIV repeat screening at 28 weeks in high-risk populations undertaken (Y/N/NA)		
113	Identification of risk factors in subsequent antenatal visits (Y/N)		
114	Total number of antenatal visits for low risk pregnancy (Y/N/NA)		

Intrapartum care

#	General criterion intrapartum care	Result	Comment
Initial assessment			
115	Time of initial assessment/clinical observations commenced documented (Y/N)		
116	Gestational age documented (Y/N)		
117	Documentation of pregnancy complicatons (Y/N)		
118	Documentation of antenatal investigation results (Ultrasounds, GBS status, Blood Group & ab screen, FBE & Hb, GTT, infectious disease screen) (Y/N)		
119	Length strength and frequency of contractions is documented (Y/N)		
120	Vaginal loss is documented (Y/N)		
121	Pulse is documented (Y/N)		
122	BP is documented (Y/N)		
123	Temperature is documented (Y/N)		
124	Respiratory rate is documented (Y/N)		

#	General criterion intrapartum care	Result	Comment
125	Urinalysis undertaken and recorded (Y/N)		
126	Palpation of the abdomen is documented (Y/N)		
127	Vaginal examination if the woman in established labour is documented (Y/N/NA)		
128	Method of fetal surveillance documented (Y/N)		
129	Appropriate method of fetal surveillance for initial assessment with consideration of antenatal risks? (Y/N)		
130	Results of fetal surveillance documented (Y/N)		
131	Risk factors that may lead to transfer to obstetric lead care identified and documented? (Y/N/NA)		
132	Determination of suitability of midwifery led care? (Y/N)		
Induction of labour			
133	BISHOP score documented (Y/N/NA)		
134	Method of induction documented (Y/N/NA)		
135	CTG undertaken and documented pre induction and until active labour established (Y/N/NA)		
136	Induction appropriate to consideration of indications and risk factors? (Y/N/NA)		
Monitoring of first stage labour			
137	Time first stage commenced documented (Y/N)		
138	Pulse documented (every half hour) (7) (Y/N)		
139	Respiratory rate (Y/N)		
140	BP documented (every two hours) (7) (Y/N)		
141	Temperature documented (every four hours) (7) (Y/N)		
142	Analgesia administration documented (Y/N/NA)		
143	Palpation of the abdomen documented (Y/N)		
144	If fetal surveillence was undertaken primarily through auscultation, was this undertaken every 15-30 minutes in the first stage of labour and documented (2) (Y/N/NA)		

#	General criterion intrapartum care	Result	Comment
145	If fetal surveillence was undertaken through CTG (as appropriate to fetal condition) was there evidence of review every of 15-30 minutes (clinican digital and written signature), interpretations recorded (at least hourly) and appropriate action taken (2) (8) (Y/N/NA)		
146	Appropriate method of fetal surveillence with consideration of intrapartum risk factors? (Y/N)		
147	Vaginal Examination documented (approx every four hours) (9) (Y/N)		
148	Maternal fluids documented (Y/N)		
149	Partogram documented labour progress(Y/N)		
150	Adequate progress in first stage labour? (Y/N)		
151	Appropriate response to delayed progress in first stage labour? (Y/N/NA)		
Monitoring of second stage labour			
152	Time second stage commenced documented (Y/N/NA)		
153	Pulse documented (every hour) (7) (Y/N)		
154	BP documented (every hour) (7) (Y/N)		
155	Temperature documented (every four hours) (7) (Y/N)		
156	Maternal fluids documented (Y/N)		
157	If fetal surveillence was undertaken primarily through auscultation were results recorded after each contraction or at least every five minutes in the active second stage of labour (2) (8) (Y/N/NA)		
158	If fetal surveillence was undertaken through CTG was there of evidence review at least every 5 minutes or after each contraction (clinican digital and written signature), and appropriate action taken (2) (8) (Y/N/NA)		
159	Appropriate method of fetal surveillence? (Y/N)		
160	Was the obstetric team notified of suspected delayed progress for primiparous at 1 hour of active second stage or for multiparous at 30 minutes (10) (Y/N/NA)		
161	Was referral of care to obstetric team for operative birth made for primiparous at 2 hrs and multiparous at 1 hr (9) (Y/N/NA)		
162	What was the average decision to delivery interval for emergency caesarean section? (Y/N/NA)		

#	General criterion intrapartum care	Result	Comment
163	If Fetal Blood Sampling was (11) available in service and indicated was this undertaken and recorded (Y/N/NA)		
Monitoring of third stage labour			
164	Maternal general condition recorded (Y/N)		
165	Time of cord clamping recorded (Y/N)		
166	Vaginal blood loss documented (Y/N)		
167	Use of a uterotonic agent documented(Y/N)		
168	Appropriate uterotonic agent administration? (Y/N)		
169	Application of controlled cord traction documented (11)(Y/N)		
170	Time, condition, structure, cord vessels and completeness of delivery of placenta is recorded (Y/N)		
171	If paired cord blood sampling was indicated (2) during labour was this undertaken? (Y/N/NA)		
Referral and transfer			
172	Was escalation of care and referral to a more experienced practitioner indicated at any stage of labour? (Y/N/NA)		
173	If yes, was the decision to escalate made in a timely way? (Y/N/NA)		
174	If yes, was the woman reviewed in a timely way? (Y/N/NA)		
175	Was the transfer of care to another maternity facility indicated at any stage of labour? (Y/N/NA)		
176	If yes, was the decision to transfer made in a timely way? (Y/N/NA)		
177	If yes, was the woman transferred in a timely way? (Y/N/NA)		

Post natal care

#	General criterion postnatal care	Result	Comment
Initial post natal maternal assessment			
178	Temperature documented (9) (Y/N)		

#	General criterion postnatal care	Result	Comment
179	Pulse documented (9) (Y/N)		
180	Blood pressure documented (9) (Y/N)		
181	Abdominal palpation for position of uterus is recorded (9) (Y/N)		
182	Volume of urine passed documented (Y/N)		
183	Recording of perineal assessment and management (9) (Y/N)		
184	Maternal emotional health documented (Y/N)		
185	Feeding of baby recorded (Y/N)		
Initial neonatal care			
186	Apgar score at 1 minute (9) (Y/N)		
187	Apgar score at 5 minute (9) (Y/N)		
188	Vit K adminstered and documented(Y/N)		
189	Hourly temperature, Respiratory rate, pulses rate, colour,tone and cord check for first 4 hours documented for uncomplicated birth and as appropriate for birth complications (9) (12) (Y/N)		
Maternity ward postnatal care			
190	Periodic (change of shift, ward round) maternal health assessment documented for normal labour (wellbeing, major systems review, feeding, wound status, vaginal loss, urinary voiding) (Y/N)		
191	Neonatal 4 hourly temp, heart rate respiratory rate for 24 hours documented for normal labour and birth (12) (Y/N)		
192	Copy of discharge plan/letter in records (Y/N)		
193	Date and time of discharge documented (Y/N)		
194	Record of follow up appointment date and time in discharge plan (Y/N)		
195	Record of medication prescribed in discharge plan (Y/N)		
196	Interventions provided in maternity service recorded in discharge plan (Y/N)		
197	Key contacts recorded in discharge plan (Y/N)		
198	Self management strategy recorded in discharge plan (Y/N)		

This next section of Part 4 of the patient record review examines criteria in specific sub populations. The subpopulation included in the audit and the sample size would be confirmed in the planning process and scoping of the internal audit.

#	Population: Post partum haemorrhage	Total no. of patients who meet criteria (Numerator)	Total number of patient files examined (Denominator)	Percentage (Numerator/ Denominator x 100)	Assessment of severity rating (high, medium and low) and recommendations
199	Post partum haemorrhage risk was identified antenatally				
200	Method of assessment of blood loss documented				
201	Estimate of volume of blood loss documented				
202	Oxygen saturation documented (11)				
203	Pulse recorded (11)				
204	Respiratory rate documented				
205	Urinary output (11)				
206	If rapid blood loss was timely assistance for escalation of care documented				
207	IV access established in a timely manner				
208	Was oxygen administered and documented				
209	Were appropriate resuscitation protocols administered				
210	Management of PPH appropriate to the cause (repeat ueterotonic agent, uterine massage etc),				

Population: Additional specific population agreed with organisaton	Total no. of patients who meet criteria (Numerator)	Total number of patient files examined (Denominator)	Percentage (Numerator/ Denominator x 100)	Assessment of severity rating (high, medium and low) and recommendations
Agreed criteria for population				