Northwest Territories Health and Social Services

Reference Guide for completion of the NWT Prenatal Record

The 2008 Prenatal Record was designed as a source of information for the maternal health care provider, as a source of communication amongst maternal health care providers, and as a mechanism for review of the quality of care provided to the client. The Maternal-Perinatal Committee recommends that the Prenatal Record and relevant laboratory results be faxed routinely to the hospital at 36 weeks gestation; and earlier if indicated and especially with any early ultrasound request.

1. Please fill out the standard historical information, ideally by the primary care giver at the first visit.

   a. The support person could be spouse, newborn's father, friend, family member. Answer may indicate a referral.

   b. The primary care giver may/may not be the same as the physician/midwife. It may be a community health nurse or several community health nurses or a nurse practitioner.

   c. The space on the upper right side is for the addressogram.

   d. Informed consent for sharing of the prenatal record is not needed if the information is being shared in the circle of health care providers who would normally be seen in a clinic or hospital setting, or if it is legislated to be shared. Informed consent is needed with the disclosure of specific personal information collected on the Prenatal Record to social workers, massage therapists, mental healthy workers, addictions workers.

   e. Additional Obstetrical history can be added onto page 6).

   f. In the health, social, current, and family/genetic histories sections, there are "Y" for yes and "N" for no. Marking the appropriate box with an "X" implies that the question was asked. The social history has an added "past" or "current" choice that will requires additional boxes to be marked with an "X". Family/genetic history has an additional "maternal" or "paternal" choice to be marked with an "X". Current pregnancy has an additional date to be filled in d/m/y.. Any identified concerns would be briefly noted in the empty box at the bottom of page 1. If none of the choices are marked with an "X", or there are no comments, it signifies that the question was not asked.

   g. In the health history, the topic "Infections/STI, Herpes, HIV" includes asking about toxoplasmosis, rubella, cytomegalovirus, varicella.

   h. The Social History Section, in recognition that these factors may influence the course of Perinatal care and Perinatal outcomes, works in conjunction with the health promotion section on page 4 where further detail can be charted with the discussed concerns. Note that drugs include marijuana use. If the smoking/chewing of tobacco is a concern, then the type,

amount per day, and quit date would be noted in the concerns box at the bottom of page 1 with further comments under the respective health promotion topic.

i. Medications include traditional medications and alternate therapies.

2. The initial history should be aimed at LNMP and EDD determination. LNMP means the last normal menstrual period of length and flow of menses. The complementary physical examination should confirm this and establish uterine size. The Expected Date of Delivery (EDD) is calculated using Naegele's Rule: for a 28-day cycle, count back 3 months from the LNMP and add 7 days. For a 21 day cycle, count back 3 months from the LNMP and subtract 7 days. For a 35 day cycle, count back 3 months from the LNMP and add 7 days. The revised/confirmed EDD box is the same on pages 1 and 2, and reflects EDD determination from LNMP and U/S. If the last LNMP is not known, refer to the appropriate maternal care provider for possible ultrasound dating.

3. Any pertinent medical conditions should be treated early and/or consider consultation with referral to the appropriate consultant.

4. Physical includes BMI. Risks increase with increased BMI to both the fetus and to the mother. The NWT has chosen a BMI of 35 so that the women who most need this discussion around risks are seen and to make the best use of the resources in the NWT. A consultation with both an obstetrician and anaesthesiologist are recommended.

5. **Laboratory:**

   a. Cervical Cancer Screen – is routinely taken at the first prenatal visit, unless the client is being followed in an abnormal pap schedule already.

   b. Hb – CBC should be done at the first visit in the first trimester. If low, closer monitoring each trimester with appropriate therapy as indicated. If Hb falls below 10g/L and not responding to therapy, consider physician/nurse practitioner consultation, and further monitoring.

   c. ABO+Rh – screening done at initial prenatal visit. Rh-positive clients should have a repeat antibody screen at 26-28 weeks only if it is the client's first pregnancy or it is recommended on the laboratory results by Blood Services. Rh-negative clients require appropriate monitoring and therapy for prevention of Rh disease. If Rh-negative, repeat antibody screen per Blood Services recommendation and administer Rhogam accordingly. Rhogam should be given to Rh-negative women at 28 weeks. If given earlier, another course should be given 12-13 weeks after the first course.

   d. Maternal Serum Screening (QUADRUPLE screen) is offered to all pregnant women in the NWT, through an informed consent process and regardless of maternal age (SCOGC Guidelines No. 187 *Prenatal Screening for Fetal Aneuploidy*, February 2007). It screens for Down Syndrome, Open Neural Tube Defects, and Trisomy 18. Timing of the screen can only be done between 15 and 20 weeks of pregnancy, optimally at 16 weeks. Accurate estimation of gestational age is extremely important.

   e. Amnio/CVS – patients who will be over the age of 35 (singleton) or 32 (twins) at the time of delivery, and/or patients with first degree relatives with neural tube defects/spina bifida should receive appropriate counselling for, and be offered genetic testing.

6. **Infection Screening:**

   a. Serology for the demarcated infective agents should be done at the first prenatal visit. TSH is done if indicated.

   b. Appropriate cervical and vaginal cultures required on initial prenatal visit. Repeat swabs are commended at 36 weeks.

   c. If any cultures return positive, refer to STI and Vaginitis in pregnancy in the STI Treatment Guidelines. If still uncertain

about appropriate therapy, consult referral physician/Health Protection Unit DHSS. (ref *Canadian Guidelines on STIs* 2006)

d. GBS – refer to current guidelines for GBS (Group B streptococcus) prevention strategies in the third trimester. Recto/vaginal swab is not taken at the initial prenatal visit, but at 35-37 weeks gestation. (Ref, *SOGC Guidelines*, 2004, Centres for Disease Control Guidelines on GBS, Aug. 2002)

e. Urine – midstream urine (MSU) using clean technique for C&S – ideally late in the first trimester or early in the second trimester and then as required from the results of the POCT routine urinalysis. Indicator of asymptomatic bacteria and GBS colonization

7. Postpartum Immunizations needs are indicated from the serology screening. The boxes flag that specific immunizations are/are not needed. "X" Marked boxes do not mean that the immunizations were given.

8. **Gestational Diabetes/GDM** – routine Oral Glucose Challenge Test (OGCT) of 50G is done between 24-28 weeks of gestation. Abnormal values of greater than or equal to 7.8 mmol/L at 1 hour is considered positive and will need follow-up with Oral Glucose Tolerance Test (OGTT) of 75G for proper diagnosis and treatment. If the OGCT is greater than or equal to 10.3 mmol/L, then the patient is diagnosed with GDM and does not need further testing. If the patient has a history of GDM or is otherwise at high risk e.g. morbid obesity, strong family history, previous stillbirth, give the initial OGTT at 16-20 weeks, and if negative then followed by a second one at 24-28 weeks. Consider physician consultation. (ref SOGC CPG November 2002 *Screening for Gestational Diabetes Mellitus)*

9. Confirmed EDD should reflect LNMP, clinical examination, +/- U/S confirmation preferably with an early (<20 weeks) ultrasound.

10. One screening ultrasound recommended at 16-20 weeks, ideally at 18 weeks gestation. Follow-up scans are not routine and are at the discretion of the referral midwife, nurse practitioner or physician.

    If the dates are uncertain, then a first trimester ultrasound is recommended (SOGC CPG *The Use of First Trimester Ultrasound*, October 2003). In this case, a follow-up ultrasound is recommended at 18 weeks gestation.

11. **Prenatal visits** Part 2 (an additional sheet for visits has been added to prevent repetition of other information):

    a. Clients should be seen routinely Q4 weeks to 28 weeks, Q 2 weeks from 29-36 weeks, and every week thereafter until delivery. If clinical situation requires it, schedule visits more frequently. Additional visits at 34 and 35 weeks are recommended in communities from where the patient will eventually need to be transported.

    b. The prenatal record aids in determining fetal growth and documenting maternal well-being. It is important to follow trends and act upon abnormalities as soon as possible.

    c. In particular, SFH (symphyseal-fundal height) and gestational weeks should correlate each week after 20 weeks. Suspicion should be raised if SFH does not exhibit the predicted growth +/- 2 cm or does not increase over a 3 week period. An appropriate referral for possible ultrasound should be considered. (Ref. Martin (2003) *Intrapartum Management Modules*).

    d. Movement and SFH should be documented with each visit.

12. Risk factors/Concerns, anticipated from the history and physical, would be documented in the Pregnancy/Delivery, Postpartum/Newborn box (found bottom of Part 2). It is expected that these factors would be addressed at a prenatal visit, delivery, or the neonatal period. e.g. VBAC, or infant requires Hepatitis B Vaccine. It should be an itemization of any conditions that may complicate this pregnancy. As a

result, a referral plan may be indicated and identification of the referrals identified in the Referral Plan box.

13. Part 3: the Pregnancy Risk Assessment have been revised and no longer includes a score. The lists do not replace the need for a comprehensive understanding of prenatal management. It is expected that identification of one or more of these risk factors would prompt appropriate consultation and flag the maternal health care provider that this client needs more diligent monitoring.

14. T-ACE questionnaire, included on the Risk Scoring sheet, is an effort to quickly identify women at risk for alcohol abuse in pregnancy. T-ACE is a measurement of four questions that are significant issues of risk drinking. The T-ACE questionnaire should be completed at intake on all clients. The T-ACE score has a range of 0-5. The value of each answer to the four questions is totalled to determine the final T-ACE score. Any positive results indicate exploration of women's drinking i.e. further questions.(ref National Institute on Alcohol Abuse & Alcoholism, Oct 2004). A client should be referred to an addictions worker if she has a score of greater than 2 or if the Tolerance question answer is greater than 2 drinks. Any plans to quit or to follow-up would be discussed and charted under the health promotion topics on page 4.

15. SAFE screening tool has been added. Healthy Relationships and domestic violence questions are intended to be asked throughout pregnancy. An "X" in the box signifies that the topic was discussed individually with the client to identify the nature of the relationship, the manner for resolving arguments, and the presence of physical, emotional or sexual abuse. This tool can be easily worked into a general conversation. If concerns arise, consider referral to appropriate resources. (Ref. *EpiNorth* 2007 Spousal Violence in the NWT: Implications for Health Care Providers).

16. The nutritional recall chart is similarly intended to identify women who are at risk for deficiencies. If any concerns in any area arise, consider referral to appropriate consultant.

17. Health Promotion Topics Part 4 for conversation listed are issues throughout pregnancy. An "X" on the box signifies that the topic was discussed. If any concerns in any area arise, document under the comments section and consider referral to appropriate consultant e.g. nutritionist, addictions worker.