

## ATTACHMENT E

### Augmentation Pre-Checklist

**Augmentation of Labor:** Stimulation of ineffective uterine contractions after the spontaneous onset of labor.

**Do not Initiate Augmentation if checklist cannot be completed.**

Y	N		Initials	Comments
		Physician/CNM order for augmentation		
		Physician with Cesarean Section privileges aware of augmentation, is readily available and this is documented in the medical record <i>(if order written by physician or CNM without Cesarean Section privileges)</i>		
<b>Shaded* items below may be delayed for augmentation of labor</b>				
		* H&P (physician L&D admission form) on chart, within 24 hours of admission		
		* Prenatal (PN) Record on chart		
		* Adequacy of pelvis documented (H&P or PN Record)		
		Estimated fetal weight or fundal height documented (H&P or PN Record)		
		Gestational age documented		
		Cervical exam or Bishops score documented		
		Fetal presentation assessed and documented		
		EFM x 30 minutes (minimum)		
<b>FHR Assessment Criteria Met</b>				
		<u><b>All criteria must be met</b></u> <ul style="list-style-type: none"> <li><input type="checkbox"/> At least 1 acceleration of 15 bpm x 15 seconds in 30 minutes, or moderate variability for 10 of the previous 30 minutes.</li> <li><input type="checkbox"/> No more than 1 late deceleration occurred in previous 30 minutes.</li> <li><input type="checkbox"/> No more than 2 variable decelerations greater than 60 sec. and less than 60 bpm below baseline within the last 30 min.</li> </ul>		
<b>Uterine Assessment Criteria Met</b>				
		<u><b>All criteria must be met</b></u> <ul style="list-style-type: none"> <li><input type="checkbox"/> No more than 5 Uterine Contractions (UCs) in 10 min. averaged over 30-min. window.</li> <li><input type="checkbox"/> No more than 2 UCs lasting longer than 120 sec. in last 30 min.</li> <li><input type="checkbox"/> Uterus palpates soft between UCs.</li> </ul>		
<b>All Criteria Met/Not Met</b>				
		<u>All</u> Checklist Criteria met		
		Checklist Criteria <u>not</u> met, Physician/CNM notified		

***Physician/CNM order and plan of care should be documented if criteria are not met and physician/CNM decides to proceed with augmentation.***

Nurse Signature: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_