Antenatal Clinical Pathway

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AVVRG celebrating 10 years of collaboration in Health Education

HCMC - 2012

Bệnh án lâm sàng tiền sản

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Aims of a Clinical Pathway

- To improve the continuity and co-ordination of care for the patient from a multidisciplinary team of health care professionals
- To use evidence based best practise to manage patient's care.
- To improve outcomes for the patient.

MỤC ĐÍCH

- Tăng cường tính liên tục và sự phối hợp trong chăm sóc bệnh nhân của đội ngũ y tế liên chuyên khoa.
- Quản lý chăm sóc bệnh nhân bằng việc thực hành tốt nhất dựa trên chứng cứ.
- Cải thiện kết quả chăm sóc bệnh nhân.

What is a clinical pathway?

- A clinical pathway is a multidisciplinary management tool based on evidence-based practice for a specific group of patients with a predictable clinical course, in which the different tasks (interventions) by the professionals involved in the patient care.
- Outcomes are tied to specific interventions.

Bệnh án lâm sàng là gì?

- Bệnh án lâm sàng là công cụ quản lý liên chuyên khoa dựa trên thực hành theo chứng cứ dành cho một nhóm bệnh nhân cụ thể có bệnh cảnh lâm sàng tiên đoán được. Trong đó có những can thiệp khác nhau của các chuyên ngành khác nhau.
- Kết cục của BN gắn liền với các can thiệp chuyên biệt đó.

Clinical pathway

Instructions for use

- It is a legal document and must be completed correctly
- It is designed for multidisciplinary team
- All staff are responsible for individual aspects of care, or assessing individual outcomes and must initial and sign the appropriate areas on the chart.

Bệnh án lâm sàng

Hướng dẫn sử dụng

- Đó là một hồ sơ có tính chất pháp lý và phải được ghi chép một cách chính xác.
- Được thiết kế cho đội ngũ nhân viên y tế liên chuyên khoa.
- Tất cả các nhân viên y tế chịu trách nhiệm cho mỗi chuyên khoa của mình, hoặc đánh giá hiệu quả cá nhân và phải ghi tắt tên và ký vào các cột thích hợp.

Front page

- All sections should be filled in as information is obtained
- This pathway can be used for up to 3 admissions in one pregnancy.

Trang đầu

- Điền đầy đủ các thông tin trong các mục.
- Hồ sơ này có thể được sử dụng đến 3 lần nhập viện trong một thai kỳ.

Front Page

Blood Group | Rubella Status | Maternal GBS Status | Steroids
Anti D Date 1 | Immune / Non-immune | Negative / Positive / Unknown | Date 1
Date 2 | | | Date 2
Date 3

ALLERGIES:

FAMILY AND SOCIAL HISTORY:
Partner / Next of Kin
Cultural / Religious Requirements
Interpreter
Dietary Requirement

RELEVANT MEDICAL / OBSTETRIC HISTORY / COMPLICATIONS:

ISSUES / CONCERNS:

SMOKING: Y / N PER DAY: ADVICE / INFORMATION GIVEN:
CESSATION DATE:

Trang đầu

Blood Group | Rubella Status | Maternal GBS Status | Steroids
Anti D Date 1 | Immune / Non-immune | Negative / Positive / Unknown | Date 1
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ALLERGIES:

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Dietary Requirement

RELEVANT MEDICAL / OBSTETRIC HISTORY / COMPLICATIONS:

ISSUES / CONCERNS:

SMOKING: Y / N PER DAY: ADVICE / INFORMATION GIVEN:
CESSATION DATE:

Blood Results

Blood Group	Rubella Status	Maternal GBS Status	Steroids
Anti D Date 1	Immune / Non-immune	Negative / Positive / Unknown	Date 1
Date 2			Date 2
			Date 3
ALLERGIES:			

- Blood group- If negative blood group, date of Anti D given
- Rubella and Group B Streptocci status
- Administration of steroids
- Allergies; also need to note allergies on medication chart and patient identification label

Kết quả XN máu

Blood Group	Rubella Status	Maternal GBS Status	Steroids
Anti D Date 1	Immune / Non-immune	Negative / Positive / Unknown	Date 1
Date 2			Date 2
			Date 3
ALLERGIES:			

- Nhóm máu- nếu Rh âm tính - ngày tiêm anti D
- Tình trạng nhiễm Rubella và Streptocci nhóm B
- Ngày tiêm steroids.
- Dị ứng; ghi chú các loại dị ứng lên phiếu thực hiện thuốc, và lên lắc tay bệnh nhân.

Family and Social History

FAMILY AND SOCIAL HISTORY:
Partner / Next of Kin
Cultural / Religious Requirements
Interpreter
Dietary Requirement

- Partner /next of kin- has the patient got family? Are they able to visit and support?
- Cultural/Religious requirements- head clothing, time and area to pray, dietary restrictions
- Interpreter-
- Dietary requirements- allergies, vegetarian,religious requirements

Tiền sử gia đình và xã hội

FAMILY AND SOCIAL HISTORY:
Partner / Next of Kin
Cultural / Religious Requirements
Interpreter
Dietary Requirement

- Chồng/ người thân- Bệnh nhân có gia đình? Họ có thể đến thăm và hỗ trợ không?
- Những tập tục tôn giáo/ văn hóa- áo trùm đầu, thời gian và nơi cầu nguyện, ăn kiêng.
- Thông dịch viên.
- Những yêu cầu ăn kiêng-dị ứng, ăn chay, tôn giáo.

Medical and Obstetric History and Issues/Concerns

RELEVANT MEDICAL / OBSTETRIC HISTORY / COMPLICATIONS:
ISSUES / CONCERNS:

- May have other condtions present prior to admission.
- May develop other condtions during admission
- Issues/concerns- also must be documented on page 4.

Tiền sử nội khoa và sản khoa các vấn đề lưu ý

RELEVANT MEDICAL / OBSTETRIC HISTORY / COMPLICATIONS:
ISSUES / CONCERNS:

- Có thể có những bệnh khác trước khi nhập viện.
- Có thể phát sinh những bệnh khác trong thời gian nhập viện.
- Các vấn đề lưu ý - cũng phải được ghi vào hồ sơ ở trang 4.

Other issues

SMOKING: Y / N	PER DAY:	ADVICE / INFORMATION GIVEN:
CESSATION DATE:		

- Does the woman smoke? Has she ceased smoking?

Ward orientation on admission	Y / N	Weight:	Booking BMI	
		Height:	Anaesthetic referral if >35	Y / N

- Orientation to the ward-amenities, visiting hours etc
- Weight and height.
- Body mass index- if obese, may need anaesthetic referral, if caesarean needed

Các vấn đề khác

SMOKING: Y / N	PER DAY:	ADVICE / INFORMATION GIVEN:
CESSATION DATE:		

- Bệnh nhân có hút thuốc không? Bệnh nhân có ngừng hút thuốc không?

Ward orientation on admission	Y / N	Weight:	Booking BMI	
		Height:	Anaesthetic referral if >35	Y / N

- Quan tâm đến các tiện nghi sinh hoạt, phòng nằm, giờ thăm bệnh….
- Cân nặng và chiều cao.
- Chỉ số khối cơ thể- nếu béo phì, có thể cần chuyển hội chẩn gây mê nếu mổ lấy thai.

Allied health/specialist referral

- As pathway is **multidisciplinary** tool, referrals to other health professionals must be documented in this area

ALLIED HEALTH/SPECIALIST REFERRAL *(please circle)*

MBU	Yes / No / Not Applicable	
Dietitian / Diabetes Educator	Yes / No / Not Applicable	
Paediatrician	Yes / No / Not Applicable	
Parent Education	Yes / No / Not Applicable	
Pastoral Care	Yes / No / Not Applicable	
Physiotherapist	Yes / No / Not Applicable	
Social Worker	Yes / No / Not Applicable	
Tour of SCN	Yes / No / Not Applicable	

Chuyển các chuyên khoa liên quan

- Hồ sơ bệnh án là một công cụ liên chuyên khoa, khi chuyển BN đến các khoa khác, nhân viên y tế phải ghi trong phần này.

ALLIED HEALTH/SPECIALIST REFERRAL *(please circle)*

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Parent Education	Yes / No / Not Applicable	
Pastoral Care	Yes / No / Not Applicable	
Physiotherapist	Yes / No / Not Applicable	
Social Worker	Yes / No / Not Applicable	
Tour of SCN	Yes / No / Not Applicable	

Other instructions

INSTRUCTIONS FOR USE

This pathway is intended as a guide only. The woman must continue to be assessed individually as to the appropriateness of each intervention and each outcome being achieved.

- This is a legal document and as such must be completed correctly. Use black pen.
- This chart is designed for a multidisciplinary team.
- **All staff** (medical, paramedical and midwives) are reponsible for individual aspects of care or assessing individual outcomes, are to initial in the appropriate area and sign at the bottom of the chart.
- This document is to be kept at the woman's bedside with the medication and observation charts.
- You may enter N/A, only if a procedure or intervention is not appropriate.

Admission completed by: ____________ Date: / /

Print Name / Signature / Designation

- The pathway is kept at the bedside, so all health professionals are able to access it easily.
- It must be signed by the midwife on admission

Các chỉ dẫn khác

INSTRUCTIONS FOR USE

This pathway is intended as a guide only. The woman must continue to be assessed individually as to the appropriateness of each intervention and each outcome being achieved.

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- You may enter N/A, only if a procedure or intervention is not appropriate.

Admission completed by: ____________ Date: / /

Print Name / Signature / Designation

- Hồ sơ này được để ở đầu giường, để nhân viên y tế có thể theo dõi một cách dễ dàng.
- Hồ sơ phải được NHS nhận bệnh ký.

Admission antenatal assessment

ANTENATAL ASSESSMENT STANDARDS
Antenatal assessments are to take place on admission to the antenatal ward and on a daily basis during the hospital stay.
1. 'On Admission' Antenatal Assessment a. Medical Officer admission – documented in progress notes of patient record file b. Midwifery admission; i. complete pages: Antenatal Clinical Pathway and Clinical Observation chart ii. refer to Medical Officer admission 2. 'Daily' Antenatal Assessment a. Minimum observations as outlined below, and b. Refer to progress notes in patient record file

- Admission antenatal assessment should be undertaken and documented as instructed on the clinical pathway.
- Medical admission should be documented on the progress notes in the patients medical history
- Other health professionals may document in the progress notes as needed.

Đánh giá bệnh nhân lúc nhập viện

ANTENATAL ASSESSMENT STANDARDS
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- Nên đánh giá bệnh nhân lúc nhập viện và ghi hồ sơ theo đúng chỉ dẫn trong bệnh án.
- Chỉ định điều trị nên được ghi vào phần diễn biến bệnh trong bệnh sử nội khoa.
- Các nhân viên y tế khác có thể ghi hồ sơ phần diễn tiến bệnh nếu cần.

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Daily antenatal assessments

DAILY ANTENATAL ASSESSMENT – CORE CARE	
Maternal	**Fetal**
Vital Observations- Pulse, Temp, BP	Fetal Movements felt
***Abdo Palpation* (exclude APH/TPL)** Lie, presentation	Fetal heart heard (24 weeks +)
Other PV loss, bowel, oedema,	**Social/Allied Health Assessment**
DVT assessment: Examine lower legs and confirm with the woman the presence of any pain, heat, redness, tenderness, oedema and changes in skin colour. Medical review and calf measurements are indicted if there is swelling	Discussion of services available & / or required Medication requirements: Condition specific, pregnancy specific and individual needs Pathology / other test requirments - ensure up to date Education requirements
NOTE: The above are minimum observation requirements. More frequent and/or specific observations are required if; (clinical judgement suggests more frequent observations are indicated OR (as part of medical management orders, OR (the presence of any condition in the following table	

- These are minimum obsevational requirements
- More frequent observations will be needed depending on the condition

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Theo dõi hằng ngày BN tiền sản

DAILY ANTENATAL ASSESSMENT – CORE CARE	
Maternal	**Fetal**
Vital Observations- Pulse, Temp, BP	Fetal Movements felt
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- Những theo dõi này là yêu cầu tối thiểu.
- Cần theo dõi thường xuyên hơn tùy thuộc vào từng tình trạng bệnh.

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Observations

- Observations should be documented on-
- Antenatal record of clinical observations
- Any concerns or variances in condition, or changes should be documented on page 4

Sự theo dõi

- Sự theo dõi nên được ghi vào hồ sơ.
- Ghi nhận theo dõi lâm sàng BN tiền sản.
- Có bất cứ vấn đề gì hoặc thay đổi gì thì ghi nhận vào trang 4.

Specific Obsevations

- Condtions that require more frequent observations are listed.

SPECIFIC OBSERVATION REQUIREMENTS FOR THE FOLLOWING CONDITIONS	
Premature Rupture of Membranes Risks: Intrauterine infection, Premature labour, Cord prolapse Observations: (4 hourly temperature, pulse pad check **NB Must sight pad to check loss** (CTG as ordered	**Hypertension / Pre Eclampsia** Risks: Superimposed PE / Eclamptic fit / HELLP Observations: (4 hourly BP (Urinalysis for protein daily (Worsening oedema (CTG as ordered
APH / Placenta Praevia Risks: Haemorrhage, maternal / fetal compromise Observations: (maternal pulse & BP 4 hourly when actively bleeding (pad check 4 hourly when actively bleeding otherwise daily (Fetal heart am / pm or more frequently if PV loss is significant, perform CTG (Rh status / Anti D if needed (If vasa praevia and fresh PV bleeding - CTG and code pink (Specific pathology attended to	**Threatened Premature Labour** Risks: Premature delivery Observations: (Hourly observations if contracting / fetal heart check am / pm (CTG as ordered (Documentation of contractions and corresponding fetal heart (Medical assessment if contracting **Polyhydramnios** Risks: Cord prolapse Observations: (Intact membranes (FHH assessment (Medical assessment if ROM
Shortened Cervix Risks: Premature birth Observations: (Rest in bed (+/– Trendelenburg position	**IUGR** Risks: Fetal compromise Observations: (Monitor fetal movements (Encourage maternal rest and adequate diet (CTG and ultrasound as ordered

Theo dõi đặc biệt

- Những trường hợp cần theo dõi thường xuyên hơn được liệt kê như trang bên.

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Concerns

CONCERNS

A concern is an unexpected outcome or if an intervention was not completed on time.

- If a concern is evident document in the appropriate section.
- Any concern recorded must include the action taken and the outcome of that action must be dated and signed.
- All health care professionals may document concerns.

DATE / TIME	CONCERNS	ACTION PLAN	OUTCOME	PRINT NAME / SIGNATURE / DESIGNATION

Những vấn đề cần lưu ý

CONCERNS

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- Any concern recorded must include the action taken and the outcome of that action must be dated and signed.
- All health care professionals may document concerns.

DATE / TIME	CONCERNS	ACTION PLAN	OUTCOME	PRINT NAME / SIGNATURE / DESIGNATION

Concerns

- A concern is an unexpected outcome or if an intervention that was not completed on time.
- These may include-abnornamal observations
- Increased observations
- Change in care
- All health care professionals may document concerns
- If concern documented, it must also include action taken and outcome.
- Must be signed and dated

Những vấn đề cần lưu ý

- Vấn đề cần lưu ý là diễn biến bệnh bất thường hoặc khi xử trí chưa hoàn tất.
- Kể cả những theo dõi bất thường.
- Tăng cường theo dõi.
- Thay đổi kế hoạch chăm sóc.
- Tất cả các nhân viên y tế đều có thể ghi vào mục lưu ý.
- Nếu phần lưu ý được đề cập đến thì phải bao gồm hướng xử trí và kết quả.
- Phần lưu ý phải được ký và ghi rõ ngày tháng.

Conclusion

- A clinical pathway is a multidisciplinary management tool.
- It should be filled in and updated during the woman's admission.
- It should give a clear 'pathway' of her hospital admission.

Kết luận

- Bệnh án lâm sàng là một công cụ quản lý liên chuyên khoa.
- Nên điền đầy đủ và cập nhật bệnh án trong suốt thời gian BN nằm viện.
- Bệnh án phản ánh được rõ diễn tiến từ khi BN nhập viện.

References

- Mercy Hospital for Women Care Plan *www.**mercy**.com.au*

Tài liệu tham khảo

- Mercy Hospital for Women Care Plan *www.**mercy**.com.au*

THANK YOU

CHÂN THÀNH CÁM ƠN

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