KINGDOM OF CAMBODIA

NATION RELIGION KING

MINISTRY OF HEALTH

INITIAL ASSESSMENT SHEET
POCKET BOOK

January, 2020

IAS is one of guidance.
It's essential for midwives.

What is 'Initial Assessment Sheet (IAS)'?

IAS is a tool to:

1) Observe the three conditions (of women, fetus, and delivery progress), when a women visit HC for delivery
2) Conduct adequate assessment on the conditions to distinguish: **'normal (green)' 'risk of being complicated (yellow)' 'abnormal (red)'**
3) Identify and refer 'real' emergency pregnant woman **('abnormal (red)')** with proper first aid
4) Take feasible necessary actions for **'normal (green)'** or **'risk of being complicated (yellow)'**

Contents of IAS

IAS is a series of tables including essential information which should be collected. IAS covers six components as follows:

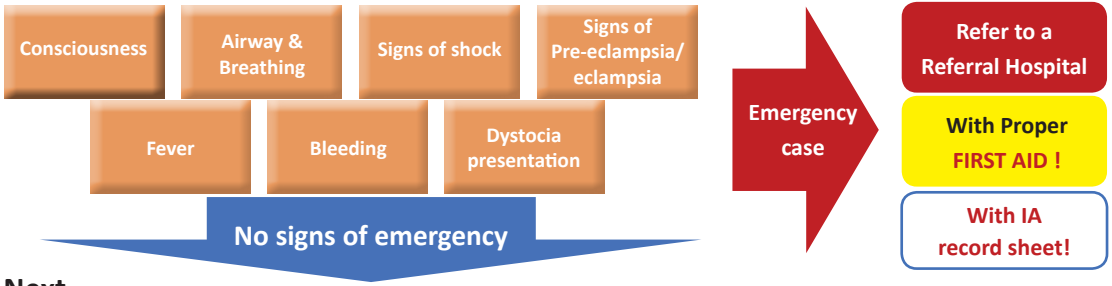
1. Immediate response to an emergency for pregnant woman
2. Listen to a women's complaint
3. Collect women's general information and obstetrical history
4. Observe fetal condition
5. Assess the delivery progress
6. Observe maternal condition

How to conduct Initial Assessment?

First,

- Following items should be **quickly** observed.
- If you find any **abnormal sign, refer** the woman immediately with proper **first aid.**

IAS Section 1

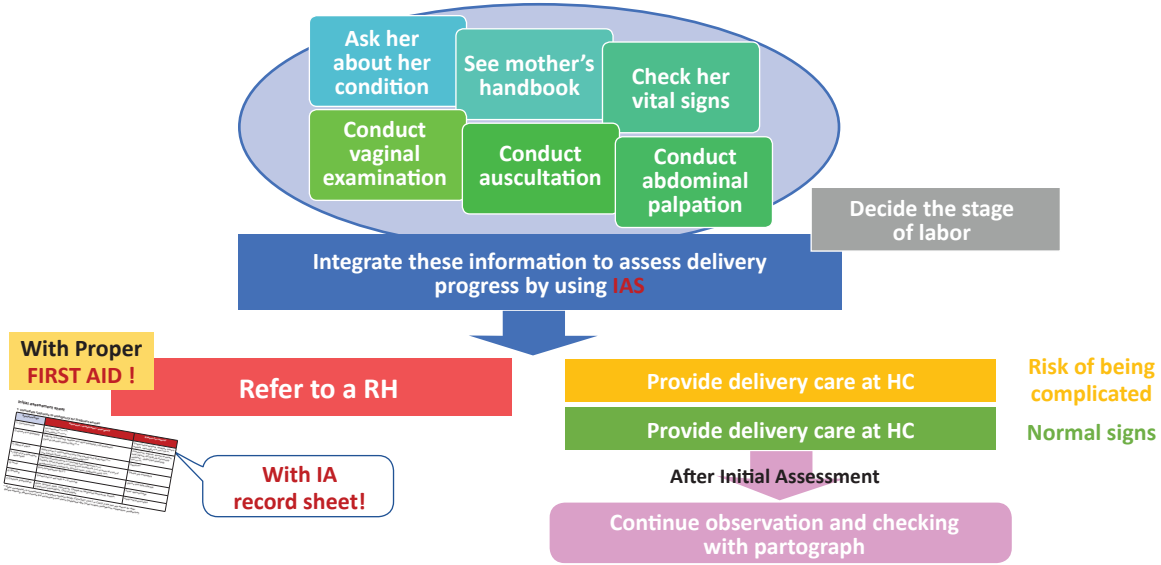


Next,

To observe and check the woman, fetus and delivery progress to judge whether she is a referral case or not,

continue to IAS Section 2-6.

Overview of assessment using IAS Section 2 - 6



1. Immediate response to an emergency for pregnant woman

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Symptom/Sign	Abnormal / complicated / emergency	Reason for referral
1) Consciousness	Unconscious[1(p13,18,23)] Convulsions[1(p18,23,24)]	Suspected eclampsia, epilepsy, severe malaria, meningitis [1(p18),2(B6),5(S53-54)]
2) Airway and Breathing	Difficulty to breathing, shallow and rapid breathing (>30 times/min) Central cyanosis (around lips)[1(p14)]	Pneumonia, asthma, severe anaemia, heart failure, APO(Acute Pulmonary oedema), obstructed breathing, [2(B3),5(S-150)]
3) Signs of shock	Rapid pulse (>100times/min) and Cold sweaty and sticky skin[1(p14)] Low Systolic Blood pressure (<90mmHg)[1(p14)]	Shock[2(B3)]
4) Sign of pre-eclam psia /eclampsia	Diastolic Blood pressure ≥110mmHg and Proteinuria (+++) Diastolic Blood pressure ≥90mmHg and Proteinuria (++) or more and any of symptoms(Severe headache, Blurred vision, Epigastric pain) [1(p24)]	Severe pre-eclampsia
5) Fever	Body temparature>38.0°C	Uterine and fetal infection
6) Bleeding	Soaked pad or wet cloth in < 5 minutes	Severe hemorrhage
7) Dystocia presentation	Brow, Sinciput, Face, Transverse, Oblique lie ,Neglected transverse, Breech, Compound presentation, Cord prolapse	Abnormal presentation

**** Refer immediately to comprehensive emergency obstetric facility (CEmONC/ CPA 2 or CPA3) if she has any reason for referral. Before referring, please provide first aid properly and check Gestational Age,Onset of labor (antepartum, intrapartum, postpartum).**

ASK!

2. Listen to a woman’s complaint

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2. Listen to a woman's complaint

2.1 Bleeding: Check 4.2. Well-being of fetus and 6. Observe maternal condition

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Quantity of bleeding	No bleeding A blood sticky (a show)[1(p47),]	Bleeding more than usual[4(p22)]	Soaked pad or wet cloth in < 5 minutes [2(B4)] →DO NOT Perform vaginal examination if it is active bleeding![1(p54)]	Suspected placental abruption[1(p35)] Suspected placenta previa[1(p36)] Suspected ruptured uterus[1(p36)]

2.2 Fluid leakage from vagina: Confirm whether membranes are ruptured(A) or intact(B)

A. Rupture of membranes: Check 4.2.2) color of amniotic fluid, 6.4) body temperature

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) The time from ruptured membranes	No rupture of membranes	Pre-labor rupture of membranes(PROM)	>18 hours past from the ruptured membranes[1(p130, 139)]	Risk of uterine infection and fetal infection[1(p130)]

B. Membranes intact: Inform the woman to report the fluid leakage from the vagina

2.3 Uterine contraction, labor pain: Check 5.2) Uterine contraction

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Uterine contraction, labor pain	Regular contraction	Irregular uterine contraction No uterine contraction	Constant pain between contractions[1(p36-37,55)] Sudden and severe abdominal pain Horizontal ridge across lower abdomen[1(p53,55)] The pain reported by the woman that differs from the pain normally associated with contractions[4(p22)]	Suspected placental abruption[1(p36)] Suspected imminent ruptured uterus[1(p36)] Suspected excessive strong pain Suspected appendicitis and other causes[5(S-142,143)]

2.4 Fetal movement: Check 4.2 Well-being of fetus

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Fetal movement	As usual, moving well	No or less fetal movement[1(p40)] →Check FHR		Suspected fetal distress or death[5(S-155)]

ASK! CHECK Mother Health Record (pink card) !

3. Women’s general information and obstetrical history

ASK! CHECK Mother Health Record (pink card) !

3. Women's general information and obstetrical history

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Gestational age at admission	Term delivery (37weeks 0day to 41weeks 6days)	Unknown	Preterm delivery(≤36weeks 6days)[1(p40), 3(p81)] Post term (≥42weeks 0days)	Premature birth Postterm birth
2) Fundal height at admission	29 - 32cm	33 - 34cm	≥35cm ≤28cm	Single large fetus and suspected Cephalopelvic Disproportion (CPD)[5(S-83)] Multiple pregnancy, Excess of amniotic fluid[5(S-101,102)] Preterm delivery or small fetus
3) Age	18 - 34 years old	16, 17 years old ≥35 years old with multipara	≤15 years old ≥35 years old or older with primipara	
4) a. Gravida			≥5 gravidas	Suspected grand multipara
b. Parity	≤3 parities	4 parities[4(p15,68)]	≥5 parities	Grand multipara, Risk of PPH[4(p68)]
c. Abortion or miscarriage	No abortion or miscarriage	≥1 abortion or miscarriage		Suspected history of surgical abortion (MVA, Curettage, Dilatation & Evacuation) and risk of PPH
5) Number of fetus	Single		Multiple[1(p91)]	Multiple pregnancy[5(S-105)]
6) Height of woman	>150	145 - 150cm	<145cm	Suspected CPD
7) Anemia	Hemoglobin >11.0 g/dl[2(C4)] No pallor[2(C4)]	Hemoglobin 8.0 - 11.0 g/dl[1(p28)] Palmar or conjunctival pallor[1(p28)]	Hemoglobin <8.0g/dl[1(p27, 56)] Severe palmar and conjunctival pallor[1(p27)]	Sever anemia[1(p100)]
8) Infectious status - HIV - Syphilis	HIV negative	Unknown HIV status[1(p31,54)] →Provide HIV test	HIV reactive or positive[1(p54)]	Risk of vertical HIV transmission[1(p107)]
	Syphilis negative	Unknown Syphilis status[1(p54)] →Provide Syphilis test	Syphilis reactive or positive[1(p28)]	Risk of congenital syphilis[1(p130,142)]
9) History of current pregnancy	No history of complication		Antepartum haemorrhage[4(p68)] History of hypertension[4(p12),5(S-50)]	Suspected placenta previa (marginal, partial or total)[1(p36)] Hypertensive disorders[5(S-50)]
10) Outcome of previous delivery	No history of complication	Forceps and vacuum extraction[1(p22)] Prior 3rd degree tear[1(p53), 2(D5), 4(p15)] Warts, keloid tissue or scars in perineum that may interfere with delivery[1(p54,69), 2(D5)]	History of pre-eclampsia, eclampsia[2(C2, C3)], convulsion[1(p22),2(C2)], PPH[1(p22, 53)] Prior delivery by caesarean section(Caesarean section scar)[1(p22,53)] History of small baby for gestation age, still birth or death first day[1(p22)]	Risk of recurrence of eclampsia, convulsion and PPH, Risk of uterine ruptures[5(S-107)]
11) Medical history	No history of complication		History of diabetes, respiratory disease, heart disease	For appropriate management[1(p159), 5(S-152,153)]

LOOK! LISTEN! CHECK!

4. Observe fetal condition

LOOK! LISTEN!CHECK!

4. Observe fetal condition

4.1 Fetal lie, presentation, position

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Fetal lie	Fetal lie parallels to uterus		Transverse, Oblique lie[1(p55,87)]	Abnormality of fetal lie, position and presentation, risk of obstructed labor
2) Fetal Presentation	Vertex presentation		Breech presentation, Shoulder presentation Brow, Face, Sinciput presentation, Compound presentation[1(p86)] , Neglected transverse, Cord prolapse	
3) Fetal Position	Occiput anterior position	Occiput posterior position[1(p84)] Occiput transverse position		

4.2 Well-being of fetus

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Fetal Heart Rate	FHR 110 - 160bpm [1(p60) 7(P74)]	FHR 100 - 110bpm [1(p53,87) 3(p53)] FHR 160 - 180bpm [1(p53,87) 3(p53)] →Place mother on left side[1(p88)] →Continue observation within 15 mins	No fetal heart beat ≤100bpm[3(p53)] ≥180bpm [3(p53)]	Fetal death, Fetal distress Suspected maternal fever, drugs causing rapid maternal heart rate (e.g., tocolytic drugs), hypertension or uterine and fetal infection[1(p87)]
2) Amniotic fluid	Clear fluid[1(p60)]	Slight meconi-um-stained fluid without foul smelling[5(S-110)] Absence of amniotic fluid after ruptured membrane[3(p53), 5(C81)]	Blood stained fluid[1] Thick meconium-stained[1(p87)] (dark green or black amniotic fluid, containing lumps of meconium)[4(p26)] Foul-Smelling[1(p41,54,56)]	Suspected placental abruption Risk of Meconium Aspiration Syndrome (MAS)[5(S-110)] Suspected fetal distress[1(p87)]

LOOK! LISTEN! FEEL!

5. Assess the delivery progress

LOOK! LISTEN! FEEL!

5. Assess the delivery progress

5.1. Decide the stage of labor

Cervical dilatation	≤3cm	Latent phase (5.2)
	>3-10cm	Active phase (5.3)
	Full dilatation	Second stage (5.4)

5.2. Latent phase

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Fetal descent -Palpation	≤3/5	4/5 - 5/5[4(p22)] [floating]		
2) Uterine contraction				Excessively strong pain Suspected placental abruption[1(p36)], ruptured uterus[1(p36,37)]
a. Frequency	≤3 times in 10mins	4 - 5 times in 10 mins	≥6 times in 10mins	
b. Duration in seconds for each contraction	20 - 40 seconds	>40 seconds	Constant pain	
c. Strength	no constant pain, have a time to rest		Tenderness, quite hard	
3) Duration of latent phase	<8hours		≥8hours	Suspected prolonged latent phase

5.3. Active phase

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Fetal descent -Palpation	≤2/5 [start to engagement]	3/5	4/5 - 5/5[4(p22)] [floating]	(Red) Suspected CPD, abnormality of rotation, malpresentation and malposition (Yellow) Risk of prolonged active phase
2) Uterine contraction				Excessively strong pain Suspected placental abruption[1(p36)], ruptured uterus[1(p36,37)]
a. Frequency	3 to 5 times in 10 mins		≥6 times in 10mins	
b. Duration in seconds for each contraction	20 to 60 seconds	>60 seconds	Constant pain	
c. Strength	no constant pain, have a time to rest		Tenderness, quite hard	
3) Moulding	(0) - (+)[1(P60)]	(++) with engagement	(++) without engagement (+++) OR Caput succedaneum without engagement	Suspected CPD[1(p60)], Risk of prolonged active phase

5.4 Second stage

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Fetal descent	Perineum begins to thin, stretch and bulge with contraction, head is visible[1(p67, 68)]	Caput succedaneum	Molding (+++)	Suspected CPD[1(p60)], Risk of prolonged labor
2) Uterine contraction				
a. Frequency	4 - 5 times in 10 mins		≥6 times in 10mins	Excessively strong pain Risk of ruptured uterus
b. Duration in seconds for each contraction	around 60 seconds	>60 seconds	Constant pain	Excessively strong pain Risk of ruptured uterus
c. Strength	no constant pain, have a time to rest		Horizontal ridge across lower abdomen[1(p37,53,55)] quite hard	Risk of ruptured uterus
3) Duration of pushing before the admission	<45mins (Primipara) <30mins (Multipara)	45mins (Primipara) [3(p46)] 30mins (Multipara) [3(p46)]	>60 mins (Primipara)* [3(p46)] >30mins (Multipara)* [3(p46)] *with poor fetal descent, severe molding, signs of Fetal distress	Suspected obstructed labor and fetal distress

LOOK! LISTEN!

6. Observe maternal condition

LOOK! LISTEN!

6. Observe maternal condition

	Normal sign	Risk of being complicated	Abnormal / complicated / emergency	Reason for referral
1) Blood Pressure	Systolic BP <140mmHg AND Diastolic BP <90mmHg	160mmHg>Systolic BP ≥ 140mmHg[4(p22),5(S-51)] OR 110mmHg>Diastolic BP ≥ 90mmHg →Please let woman take rest and measure BP 15mins later again	Systolic BP ≥160mmHg [4(p22), 5(S-51)] OR Diastolic BP≥110mmHg[1(p24)]	Pre-eclampsia, eclampsia, Gestational Hypertenion[5(S-51)]
2) Signs with hypertension	No signs of hypertension		Any of Severe head ache, Blurred vision or Epigastric pain [1(p24)]	Pre-eclampsia, eclampsia
3) Pulse	60 - 100 times/min	>100 times /min[1(p14)]		Shock[2(B3)]
4) Body Temperature	<37.5°C	37.5 - 38.0°C[4(p22)]	>38.0°C[1(p19,56,82)] with ruptured membranes[1(p56)], Foul-smelling vaginal discharge[1(p41,56)] with infection sign[1(p38-39,83)]	Suspected uterine and fetal infection[1(p56)], Lower/Upper urinary tract infection, Pneumonia, TB, Malaria[1(p38-39,83)]
5) Urinalysis	No proteinuria proteinuria (+)	Proteinuria (++)[1(p24,56)]	Proteinuria ≥ (+++)[1(p24,56)]	Pre-eclampsia, eclampsia
6) Bleeding	A blood stickey (a show)[1(p47)]	Bleeding than usual[4(p22)]	Soaked pad or wet cloth in < 5 minutes [2(B4)]	Suspected placental abruption, placenta previa (marginal, partial or total), ruptured uterus[1(p35-37)]
7) Psychological state	No complaint	Distressed, anxiety[1(p59)]		

Reference

1. Safe Motherhood Clinical Management National Protocol for health canter (2016) Ministry of Health, Kingdom of Cambodia
2. Integrated Management of Pregnancy and Childbirth, Pregnancy, Childbirth, Postpartum and Newborn care: A guide for essential practice (2015) WHO
3. Midwifery Curriculum for Health Centre (2016) NMCHC
4. Intrapartum care for health women and babies, Clinical guidelines190 (2014) NICE
5. Integrated Management of Pregnancy and Childbirth, Pregnancy, Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors (2017) WHO
6. Williams obstetrics 24th edition (2014)
7. WHO recommendations Intrapartum care for a positive childbirth experience (2018) WHO

NAME: