Instructions for the Prenatal Screening Practices Survey

Data Collection Form

General instructions:

Data from the patients' charts should always be used except for race and ethnicity, which are often missing and which can be prefilled from vital records data.

All times should be recorded as military times (e.g., 1:00 pm=1300). All dates should be recorded as month, day, 4-digit year. Throughout the form missing values should be given the following codes: An unknown time=9999; an unknown date=02/22/2222; other unknown values (e.g., number of visits, gestational age, number of doses)=99. **No variables where the answer is unknown or no should be left blank except in the two sections where skips may occur. These skips are clearly marked. Otherwise something should be filled in for every variable and a careful effort should be made to distinguish No from Unknown (described below in more detail).**

If when you go to the mom's chart you find out she had twins, please try to use the vital records birth certificate data to separate out which twin was selected for inclusion in the audit (it is highly highly unlikely that your random sample will have selected both twins but if it did that's ok). If you can't tell which twin was selected from the birth certificate number etc., then randomly pick one to include (don't always pick the twin born first).

Study ID: This 5-digit number will be pre-assigned to each chart in the data file from vital records that you are given to help locate each chart.

Hospital ID: Unique identifier for each hospital

State: This two digit variable should be the state abbreviation

Section I: Mother's Information

Most often, **maternal year of birth** and **race** can be obtained from the admission form, which is within the first few pages of the chart. Some hospitals use race codes in which case medical records staff should be able to provide a key (1=white, 2=black, etc.). Race and ethnicity may often be missing from the medical record. Do not pre-fill the birth audit form with that data from Vital Records. Rather, that information will be sent to us as a separate file. **Source of payment for Labor and Delivery,** as well as the **date and time of admission** are also found on the admission form. Use four digit year fields for dates collected and military time for times collected. **Remember, unknown dates=02/22/2222 and unknown times=9999.**

Prenatal data is often found on ACOG forms, are usually pink or yellow, and will be useful for obtaining **number of visits, date of first, date of last recorded visit, GA @ last recorded visit,** and **Estimated date of delivery (EDD). Note: Date of last prenatal visit refers to the last recorded visit in the information forwarded to the hospital**; this may not have been the woman's last visit before birth but we are collecting it so that we know her gestational age when the chart was forwarded to the hospital. Gestational age (gestage) should ideally be present on the chart. If it is not present it can be calculated from date of birth and the estimated date of delivery. If gestational age is available as weeks and days, record the exact age as weeks and days, **do not round up to the nearest integer and please use the number of days after the decimal place rather than a decimal value (e.g., 36.4=36 weeks and 4 days)**.

EDD or due date can also be located in the discharge summary, the OB admission form, or in the Labor and Delivery summary.

The Labor and Delivery summary is the best place to find **date and time of delivery**, **delivery type**. Forceps and vacuum may be checked under a complications section.

Tip: Carry a wheel used by OB/GYNs to determine EDD if none is listed.

If the mother has ruptured membranes on admission, the date and time will often be on the OB admission form. Membranes intact on admission can be found on the Labor and Delivery summary. If membranes are artificially ruptured at the time of c-section, record the time that c-section began as rupture of membranes (**ROM)** time. The time of ROM will also be in the L and D flow chart.

Section II: Intrapartum Antibiotics

IP antibiotic refers to antibiotics given to the mother after the onset of labor or rupture of the membranes and prior to the delivery of the infant. Do not record information about antibiotics administered after delivery. Intrapartum antibiotics order will be notated in the MD orders. There may be pages specially designated for antibiotic orders. For the question IAP given, check unknown only if the L and D flow chart/progress record and the MD orders are missing from the chart. Otherwise check no**. Antibiotic administration** will be in the Drug administration record and in the L and D Flow chart/progress record. Count all intrapartum doses administered. With c-sections, count only the doses administered before umbilical cord is clamped. For Antibiotic 1 and Antiobiotic 2, write the names, if unknown, but you know antibiotic was given, write unknown (do not leave blank unless no antibiotics were given). If more than 2 antibiotics were administered, record penicillin and ampicillin first and just record two antibiotic names. For number of doses, if unknown enter '99'**–do not leave blank**.

Section IV: Prenatal Testing

General instructions

The prenatal record is the best place to get test results. **If there is no prenatal information available, but you know the mother did receive prenatal care, select *U* for each test. Select *N* for each test if you know the mother did not receive prenatal care, or if you**

have prenatal care information but find no mention of that particular prenatal test. There are usually multiple notations through all sections of a chart if the mother did not receive any prenatal care.

If no record of a test is present **do not immediately skip to the next row** because there are more variables to record in that row. To try to help you, I have put variables that should not be skipped in bold.

Actual lab reports are a rare find. Most often, you must rely on notations in a Laboratory test summary page of the prenatal record. If the prenatal record is not in the chart, other sources are the Discharge summary and the OB admission form.

Date of prenatal testing refers to the date when the test was ordered, not the date the results were obtained.

GBS

In earlier audits, there were no specific areas on prenatal lab test records for GBS. It was usually difficult to find, depending on the hospital or pnc provider. Look first in the prenatal lab test summary. All of the prenatal tests will be listed by dates in this section. On the standard ACOG form (1997 version), GBS is listed under the "32-36 week labs 'when indicated' section". If **GBS** is not printed on the form, it might be written in under "Other." If nothing is recorded in this section, flip to the visit summary. Scan through the nurses notes for a **GBS test.** No luck? Try looking in the discharge summary, on the OB Admission form, or in the MD admit notes. We realized that not all prenatal records included all visits, so the information might be recorded only in the obstetric areas of the chart. If this is the case and the test was positive, it will most likely be an obvious notation, however usually no date of test or culture site will be available.

Occasionally instead of a GBS test recorded you'll see reults of a vaginal culture that grew GBS. There may be still be labs that are using a vaginal culture as an overall screen. The test is a blood agar swab and is recorded as "vag cult" or "gen cult" and sometimes next to it it

will say GBS+ or GBS- . If after 34 weeks of pregnancy you find mention of a genital culture taken, but there is no mention of specific GBS testing, check yes for GBS test, with test result unknown. If genital cultures are mentioned earlier than 34 weeks in the pregnancy and there is no specific mention of GBS testing, they probably are not GBS tests, and should not be recorded. Do not confuse with the GC/chlamydia screen.

GBS tests may be cultures or they may be rapid tests–either antigen or a recently approved PCR rapid by IDI. Tests on admission are more likely to be rapid tests. Try to determine which type of test it was from a lab slip or doctors' notes

***Tests other than GBS*:**

Primarily we are collecting information on whether a test was done and if so what the results were.

HIV

For HIV we are not collecting the results. **We would like to collect for all mothers whether there was a history of IV drug use–this variable is listed in bold in the prenatal HIV test row**. **When possible, please check under the comments box whether the Hx of IV drug use was asked for the current pregnancy ("Current"), or for the mother's lifetime ("Ever").**

HBSAG

HBSAG refers to Hepatitis B surface antigen. Sometimes this may be written as HepBSAG. The key thing is that this is a Hepatitis B surface ANTIGEN test, not an antibody test, or a Hepatitis A test.

Rubella

For rubella, unlike the other tests, the options for results are : S (susceptibile), I (immune) or U (unknown).

Syphilis

For syphilis we would like to know both a test result (positive, negative or unknown) and which sort of test was done. **If you see as test type RPR or VDRL, or if you have a lab result recorded as a titer, check the box labeled RPR/VDRL. If you see FTA, or a lab result listed as reactive/nonreactive, check FTA. If the test type is not specified and you have no lab results check unknown.** If more than one syphilis test was done, we would like to know the results of the second test.

If for syphilis you find pre-printed forms which already have pre-printed in the type of lab test done, record that information unless you have a lab slip that specifies the test done was different from the test specified on the preprinted form.

Section V: Testing Done on Admission

Unless the mother did not receive prenatal care, the only test consistently ordered on admission was syphilis. The **tests on admission** will often be in MD orders and the lab reports and results will be in the chart. If the mother did not receive prenatal care, the entire prenatal panel should be available as lab reports. Thus, if the L&D log and medical chart notes are available and there is no mention of tests on admission, the tested column should be checked no for all tests. If the L&D log and medical chart notes, MD orders, and birth summary are missing, the tested column should be checked unknown for all tests.

For GBS we have added in again which type of test was done–you may find rapid tests that were done on the delivery floor.

If mom is rubella non-immune, vaccination will often be in MD orders and in the drug administration record.

Maternal Record Audit: Guide To Obstetric Charts

Chart Component	Variables Likely Found
Admission Form	Maternal year of birth, Race/ethnicity, Source of payment labor and delivery, Date/Time admission
Discharge summary	race, did mother receive pnc, EDC, ROM, delivery type, fever and antibiotics (no times or dates), prenatal tests (results only), history of IDU
MD orders	antibiotic orders/date/time, tests on admission, IV placement
	MD admit/progress notes: admission notes are sometimes useful to scan for a general idea of the chart, includes test results noted and history
	Nurse notes:same as MD progress notes but more detailed, scan for general picture, results, relevant notations, etc.
	Prenatal Forms: DOB, race/ethnic, number of visits, dates of first and last recorded visits, GA at last recorded visit, pnc provider type, prenatal payment source, EDC, GBS bacteriuria, prior GBS baby, prenatal tests results/dates, GBS culture site, history of IDU, prior syphilis rx
	OB admitting Form: did mother receive pnc, EDC, date and time of admission, ROM, prenatal test results, tests noted on admission
Labor and Delivery summary	EDC, admission date/time, ROM date/time, delivery date/time, delivery type, IV meds including antibiotics, positive prenatal test results
Labor Flow/progress record	IP fever date/time, IP antibiotics administered, date/time/number of doses
Drug administration record	IP antibiotics administered, date/time/number of doses
Laboratory reports	tests done on admission, dates, culture sites Note - rare to find prenatal lab reports
***Locations, names of forms and tests vary with different hospitals**	

Maternal Record Audit Key

Variable	Chart Locale
Mother's Information:	
Mother's year of birth	Admission form
Race	Admission form
Ethnicity	Admission form
Did mother receive pnc	Discharge summary, OB admit form
Number of recorded visits	Prenatal forms
Date of first visit	Prenatal forms
Date of last recorded visit	Prenatal forms
GA at last recorded visit	Prenatal forms
Type of pnc provider	Prenatal forms
Payer for pnc	Prenatal forms
Payer for L and D	Admission form
EDC	Prenatal forms, OB admit form
Date/Time of admission	Admission form, OB admit form
Date/Time of delivery	L and D Summary
Type of delivery	L and D Summary
IV placed prior to delivery	L and D Summary
GBS Risk Factors/Treatment	
Date/Time of ROM	OB admit form, L and D Summary
ROM greater than 18 hours	Discharge summary, (calculate)
Fever	L and D flow/progess record
Date/Time fever noted	L and D flow/progess record
GBS positive urine	Prenatal forms
Date of urine test	Prenatal forms
Previous GBS baby	Prenatal forms
DOB for previous GBS baby	Prenatal forms
IP antibiotics	L and D flow/progess record
Date/Time of order	MD orders
Date/Time administered	Drug administration record
Type of antibiotic used	Drug administration record
Number of doses	Drug administration record

Variable	Chart Locale
Second antibiotic used	Drug administration record
Number of doses	Drug administration record
Prenatal Infectious Disease Tests	
Genital culture/result/date	Prenatal forms
Site of culture	Prenatal forms
GBS culture/result/date	Prenatal forms
Site of culture	Prenatal forms
GBS status noted on admission	OB admit form, MD progress notes
Hep B test/result/date	Prenatal forms
HBsAg status noted on admission	OB admit form, MD progress notes
HIV test/date	Prenatal forms
HIV status noted on admission	OB admit form, MD progress notes
History of IDU	Prenatal forms, Disch summary
Rubella test/result/date	Prenatal forms
First syphilis test	Prenatal forms
Type of test/result/date	Prenatal forms
Second syphilis test	Prenatal forms

Type of test/result/date	Prenatal forms
Testing done on admission	
Genital culture on admiss/result/date	MD orders, lab reports
Site of genital culture	Lab report
GBS culture on admiss/result/date	MD orders, lab reports
Site of GBS culture	Lab report
Hep B on admiss test/result/date	MD orders, lab reports
HIV on admiss test/date	MD orders, lab reports
Rubella on admiss test/result/date	MD orders, lab reports
Vaccine before discharge	Drug administration record
Syphilis on admiss test/result/date	MD orders, lab reports
Prior history of syphilis treatment	Discharge summary, prenatal forms
Treatment given	Drug administration record