

**PLU SCHOOL OF NURSING
N370 OB CLINICAL ROTATION:
Professor Gaspar
Mother-Baby Unit Documentation**

NAME of STUDENT LUCRETIA SHAFER
CLINICAL SITE ST. JOSEPH'S
CLINICAL PROFESSOR RHONDA LIZZI

DATE 1/05/2006
UNIT MOTHER/BABY UNIT

MOTHER

Pt. Initials CC

Subjective/History	Objective/PE and labs	Patient needs	Therapeutic Interventions	Evaluation
<p>(Pertinent past medical Hx, pertinent psychosocial Hx, pertinent OB/GYN Hx, current pregnancy and delivery)</p> <p>Age 20 G 2 P 2 Delivery Date 1/04/2006 Time 1350</p> <p>History of scoliosis, still has mild case. Three back surgeries, most recent 1999. First child, boy, vaginal delivery, now 16 months old. Pregnancy, labor and delivery uneventful. No menses since birth of first child. This pregnancy not planned but OK. Pre-term contractions, Terbutaline started at 28 weeks. Pt. complains of low back pain and leg weakness past 4 days. Wanted to deliver with out narcotics but asked for epidural when assured that it would not hurt the baby. Large baby, pt pushed for 2 1/2 hours. Midline episiotomy. Estimated blood loss 500cc. Allergies to morphine and latex.</p>	<p>Blood type and Rh A+</p> <p>Rubella status neg</p> <p>Hepatitis status neg</p> <p>Any other lab values</p> <p>HCT 23 16 hrs postpartum</p>	<p>Mom will not hemorrhage.</p>	<p>Assess vitals (HR, BP, Resp, pulse and pain) q8 hours to determine any change from baseline and to detect any signs of hemorrhage/shock</p> <p>Assess fundus for tone and position q2 hours to make sure that it is not boggy, enlarged or off center.</p> <p>Massage fundus q2 hours to cause it to contract and to increase uterine tone.</p> <p>Assess flow q2 hours for color, clots and amount to evaluate amount of bleeding and to determine if bleeding increases</p> <p>Assess bladder for distention to determine if bladder is interfering with fundal tone.</p> <p>Teach mom how to massage fundus and why it is important especially since she is not breastfeeding so she will be able to participate in her recovery. Assess teaching by watching mom to evaluate effectiveness of teaching.</p>	<p>BP 92/54 but pt has been close to that since coming on floor. Pulse 94. Denies dizziness, SOB, lightheadedness.</p> <p>Fundus firm, midline, at umbilicus.</p> <p>Pt. grimaced, small amount of drainage with clots expelled.</p> <p>Pad changed, moderate flow, no change from previous check.</p> <p>Bladder not distended. Pt voided 1 hour before assessment</p> <p>Mom demonstrates fundal massage and verbalizes "this will keep my uterus firm so I won't hemorrhage". Agrees to continue at home q8 hours until bleeding stops.</p>

		<p>Mom will not fall related to low hematacrit/anemia and blood loss from delivery.</p> <p>Mom will be able to express any concerns about leaving the hospital with baby</p>	<p>Assess vital signs q8 hours to determine change from baseline.</p> <p>Assess for signs and symptoms of anemia from blood loss to determine risk potential.</p> <p>Check lab values as ordered (H&H) and notify physician if indicated to inform him/her of results.</p> <p>Teach mom to sit up and stand up slowly so her blood flow can compensate for the change in height.</p> <p>Monitor I/O and diet for adequate nutrient intake.</p> <p>Provide mom with at least 240 ml/hour of fluids for hydration.</p> <p>Flush saline lock q8 hours to maintain patency for PRCs or whole blood if ordered by physician.</p> <p>Give meds as ordered by Dr. (supplemental iron).</p> <p>Observe mother-baby interactions to assess need for interventions.</p> <p>Monitor mom for signs and symptoms of emotional distress.</p> <p>Encourage mom to express feelings of distress, fear or anxiety to allow her to ventilate feelings</p>	<p>BP 92/54, pulse 94 at rest</p> <p>Mom denies any dizziness, SOB, light headedness.</p> <p>HCT 23. Dr notified</p> <p>Mom agreed to dangle feet over bedside before standing and to stand slowly.</p> <p>Mom ate 75% of breakfast.</p> <p>Water and juice provided at bedside. Mom encouraged to drink.</p> <p>IV flushed and patent</p> <p>Supplemental iron included in discharge instructions</p> <p>Mom actively engaged with baby, usually holding him, bottle feeding him, smiling and talking to him.</p> <p>Mom tired but willing to participate in care of baby, and self. Makes eye contact with nurse, asks appropriate questions</p> <p>Easily discusses marital situation, and living arrangement with parents and siblings. Does not</p>
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			<p>and have them accepted.</p> <p>Collaborate with Social Services to identify any areas of concern related to mom's home environment.</p> <p>Provide mom with referrals to community resources for mother-baby support services to provide additional resources as needed.</p>	<p>avoid or deny the problems. Displays adequate coping skills and hope for future..</p> <p>Social services contacted, counselor met with mom. No concerns noted.</p> <p>Appt with MSS arranged for next week.</p>
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		<p>Baby will not develop physiologic jaundice.</p>	<p>intake of formula.</p> <p>Monitor I/O of baby using chart and # of wet and poopy diapers to determine sufficient intake.</p> <p>Assess dirty diapers for frequency, color and consistency to monitor transition from meconium to soft yellow-brown stools indicating adequate nutrition.</p> <p>Assess bili at 24 hours to determine bilirubin level and calculate risk of developing jaundice</p> <p>Assess skin color for signs of jaundice</p> <p>Assess intake for adequate fluid/nutrition intake</p> <p>Assess diapers for wetness and stools to determine any digestion and elimination problems.</p> <p>Teach mom signs and symptoms of physiologic jaundice and when to call healthcare giver.</p> <p>Encourage mom to set up appointment with baby's doctor for 1 week check up.</p>	<p>out.</p> <p>Baby drinking 30ml/2-3 hours during shift. Two wet and poopy diapers during shift.</p> <p>Both poopy diapers transition between meconium and formula fed stools. Loose and unformed.</p> <p>Bili test results: 5.0 at 21 hours. 40% risk for developing jaundice.</p> <p>Skin pink.</p> <p>Baby consuming 30 ml/ 2-3 hours of formula</p> <p>Two wet and poopy diapers during shift.</p> <p>Mom given bili test results with explanation. Reviewed form and signed.</p> <p>Mom stated that appointment is made.</p>
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