

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

very well doc'd

NAME of STUDENT ILIA MONDOY DATE 01-29-08
 CLINICAL SITE ST. JOSEPH MEDICAL CENTER UNIT MOTHER/BABY UNIT
 CLINICAL PROFESSOR RHONDA LIZZI

MOTHER

Pt. Initials E. G Age 24 G 1 P 1 0 0 1 Delivery Date 1/29/08 Time 0526

Blood type and Rh O+ Rubella status positive Hepatitis status negative GBS status negative Any other lab values relating to this pregnancy Herpes simplex virus Positive

History	Significant Physical Examination findings	Nursing Diagnosis/Outcomes	Therapeutic Interventions	Evaluation
<ul style="list-style-type: none"> Pertinent history related to this pregnancy and this delivery- mom is a primagravida with chronic hypertension throughout pregnancy. Pre- pregnancy weight was 236 and weight at due date was 275. Blood sugar was monitored for a week during pregnancy to assess need for insulin coverage for duration, but none was needed. Estimated day of delivery was 1/19/08. Patient was admitted 1/28/08 for an induction. received an epidural. and after a lengthy labor, delivered vaginally via vacuum. 	<p>Patient's fundus is firm, midline and at umbilicus.</p> <p>Patient has a second degree laceration that was repaired. Upon visualization, the edges appeared approximated without excessive swelling. Patient complained of stinging in perineum.</p> <p>Moderate amount of lochia present. Client voided 200 ml within the 8 hours after delivery.</p> <p>Client had hypoactive bowel tones, with no passage of stool or flatus.</p> <p>Client's blood pressure upon admission to the mother/baby</p>	<p>Diagnosis: Risk for deficient fluid volume r/t postpartum hemorrhage.</p> <p>Outcome: Client will have a firm fundus, will not saturate a peri pad in one hour, and will have a scant to moderate flow.</p>	<p>Diagnosis 1: Assess vital signs: Pulse, blood pressure, respirations on admit to determine baseline.</p> <p>Collaborate with prescriber to make oxytocic agents available on a prn basis such as methergine, cytotec or pitocin to assist with uterine contraction and to minimize blood loss with hemorrhage.</p> <p>Determine amount of flow by observing lochia on peri pads and describing as scant (amount less than 2.5 cm), light (less than 10 cm), moderate (more than 10 cm) and heavy (pad saturated in 1-2 hours).</p>	<p>Evaluation 1: Outcome met. Throughout shift, fundus remained firm at midline at umbilicus. Client had moderate flow as evidenced by one peri pad with moderate lochia.</p>

<ul style="list-style-type: none"> • This is mother's first pregnancy and first child • Pertinent medical/surgery- Patient has known morphine allergy, and has a history of motion sickness with frequent episodes of emesis. Also has a history of a motor vehicle accident in which patient received a broken arm and leg. Client was diagnosed with Herpes during pregnancy, has never had an outbreak, and received • Psychosocial – patient and father of baby are not married, but father is actively involved in care, holding and interacting with infant. Family unit appears stable. Mother has had constant complaints of headache throughout shift, and pain has been difficult to alleviate. Client, father of baby and baby are all tired and have rested most of the day. 	<p>unit was 140/72.</p>	<p>Diagnosis: Risk for infection r/t repaired 2nd degree laceration</p>	<p>Assess fundus at beginning of shift and every 4-6 hours to ensure uterus is firm to prevent blood loss.</p> <p>Massage fundus and expel clots if uterus feels boggy to promote uterine contraction.</p> <p>Educate patient about importance of voiding so as not to displace uterus and interfere with involution.</p> <p>Educate patient that frequent breastfeeding will increase uterine contractions and control bleeding.</p> <p>Assess vital signs: pulse, blood pressure, respirations and skin temperature and color to assess for signs of hemorrhagic shock.</p> <p>Educate client about the importance of drinking fluids to maintain adequate fluid volume, and make available liquids.</p> <p>Diagnosis 2: Assess laceration upon admission to establish</p>	<p>Evaluation 2: Outcome met: Client had a</p>
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		<p>Outcome: Client will verbalize by end of shift ways to decrease infection in the perineal area.</p>	<p>baseline.</p> <p>Assess temperature at admission to establish baseline.</p> <p>Reassess laceration every 8 hours to reassess for redness, warmth, tenderness or swelling, signs of infection.</p> <p>Assess temperature every 8 hours to monitor for signs of infection, making sure it stays under 100.4 degrees fahrenheit.</p> <p>Educate client to wash hands before and after touching perenium to decrease risk of transmitting an infection.</p> <p>Educate client to wash perineum from vagina to anus with full peri bottle to decrease the spread of microorganisms.</p> <p>Educate client to pat perineum dry front to back, to decrease spread of infection and to minimize trauma to repair.</p> <p>Educate client to change pad every time client uses the</p>	<p>temperature of 98.7. Visual inspection of repair saw pink laceration with edges approximated and no sign of drainage. Taught client importance of cleaning area after every void front to back, and to pat dry. Patient verbalized understanding of importance of care.</p>
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			off lights and minimize noises to promote rest while recovering.	
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NAME of STUDENT ILIA MONDOY
 CLINICAL SITE ST. JOSEPH
 CLINICAL PROFESSOR RHONDA LIZZI

DATE 01-29-08
 UNIT MOTHER/BABY UNIT

BABY

Pt. Initials G. Age 3 hours

Any significant labs _____

Infant gender M

Birth weight and length 4000 gm and 21.5 inches

APGARS (@ 1 and 5minute minutes with deficits 8(-2 for pale color) 9(-1 for acrocyanosis)

breast or bottle feeding BREAST

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<p>Baby had long delivery, then delivered via cesarean due to infant's failure to descend. One minute APAR was and 8 due to white color. Five minute APGAR was a 9 due to acrocyanosis. Baby is breastfeeding, has had one stool and at end of shift had not voided.</p>	<ul style="list-style-type: none"> • Psychosocial- Both mother and father are very tired, and have been napping throughout shift. Mom has had headache that has been difficult to manage. Found baby in bed sleeping with mother and father sleeping in bed as well. 	<p>Diagnosis 2: Risk for fluid volume deficit r/t inadequate intake of colostrum AEB length of time between feedings.</p> <p>Outcome: Newborn will have at least 1 void and 1 stool by 24 hours of age.</p>	<p>after beginning skin to skin contact to determine if temperature has increased to above 97.6 degrees fahrenheit.</p> <p>Educate parents of importance of maintaining temperature for baby to prevent further heat loss, such as keeping baby double wrapped, keep hat on, and keep room temperature consistent.</p> <p>Interventions 2: Assess for wet/dirty diapers every 2 hours until baby has voided and stoolled once.</p> <p>Assess fontanels every shift to monitor nutrition- depressed fontanels is a sign of dehydration.</p> <p>Assess mucous membranes for moistness every shift to ensure adequate hydration.</p> <p>Reassess for voiding/stooling every 8 hours after initial void/stool to ensure adequate intake of fluid.</p>	<p>Evaluation 2: Outcome partially met. Baby has had one stool, but had not voided by end of shift. Baby was assessed and found not fluid deficit. Mother and father were very tired and had to be reminded to feed.</p>
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			<p>evidence of jaundice to identify rising bilirubin levels, treat promptly and prevent kernicterus.</p> <p>Assess temperature of infant every hour to assure infant maintains an adequate temperature to prevent injury related to hypoglycemia.</p> <p>Educate parents to avoid sharp objects such as long fingernails and sharp objects to prevent injury.</p> <p>Educate parents on proper techniques to hold baby, supporting head to prevent injury.</p> <p>Educate parents to place baby on back while sleeping- sleeping on back is shown to prevent SIDS.</p> <p>Educate parents that constant feeding will increase excretion of bilirubin, which can decrease risk of injury secondary to hyperbilirubinemia.</p>	
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			<p>Educate parents that baby needs assistance maintaining body temperature to avoid injury related to low body temperature, which can cause hypoglycemia.</p> <p>Assist with maintaining infant temperature by double swaddling and wearing hat and keeping room warm.</p> <p>Educate parents to not place child in high area to prevent injury.</p> <p>Educate parents to not sleep with baby in bed while in hospital to prevent injury due to suffocation or baby falling .</p>	
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