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HACKETTSTOWN REGIONAL MEDICAL CENTER

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MATERNAL SERVICES
(Scope)

TITLE: **ADMISSION OF A LABOR PATIENT PROCEDURE**

PURPOSE: To outline procedure to:
a. Prepare a pregnant patient for her labor and delivery.
b. Relieve the anxiety that may be present in the patient.
c. Ensure continuity of nursing care.

EQUIPMENT:
1. Prenatal record, folder for privacy, chart, allergy/Rh sticker if needed.
2. Fetal monitor
3. Thermometer
4. Sterile urine specimen container.
5. QS Computer System/Affinity computer system

CONTENT:	PROCEDURE STEPS	KEY POINTS
	1. Admit patient to LDR Room. Patient's name will be entered on QS blackboard via Cerner admission interface after admitting is given room number.	Ensure patient has been processed through admitting.
	2. Orient patient to LDR and L&D routines. Show support person patient refreshment area.	
	3. Have patient put on hospital gown, as desired. Obtain clean catch urine specimen.	Answer questions, reassure patient. Send specimen to lab as soon as possible.
	4. Position patient on left tilt. Patient may request to be standing or sitting in rocking chair.	Decrease pressure on Inferior Vena Cava and increase utero-placental blood flow.
	5. Apply EFM, following fetal monitoring procedure.	Document baseline/periodic changes, contraction patter in QS system Labor Annotations.
	6. Notify lab personnel to draw CBC and any other Lab work ordered by provider.	Enter labor check orders in Cerner.
	7. Complete obstetrical and health history assessment form in Cerner Power chart forms.	Check prenatal record for history/GBS status., 3rd trimester HIV testing.
	a) Consent for care in labor obtained by provider. b) Consents for pediatrician, hepatits vaccine and picture. c) Declination of administration of medications if necessary on 'Refusal of Treatment' form.	If patient too active in labor husband may sign consent for care. Patient must sign pediatric consent. Both must be witnessed by a licensed health care provider.
	8. Check for bloody show and ROM. See procedure for use of Amniosure. If membranes are ruptured, note time, quantity and color. If amniotic fluid has a foul smell or is not clear in color, notify medical provider. Any undue bleeding - notify provider.	If +ROM document time, quantity and color. Document in QS.

10. Upon receiving orders, perform SVE. Notify provider of findings.	Document in QS. Keep patient informed of findings. Answer patient questions.
11. Assemble patient chart, adhering patient ID labels to all paper forms.	Unit secretary may perform.
12. Check with provider regarding patient diet.	Provide food and fluid as ordered.
13. Verify accessibility of neonatal resuscitation box. Maternal and fetal O_2 and suction set up at bedside.	If not done previous to patient admission.
14. Assess analgesia needs/desires and inform patient of analgesia available. To administer analgesia - do Sterile vaginal exam and assess - Fax provider order to pharmacy for profiling In pyxis. - Remove profiled medications from pyxis, scan patient's wrist band barcode, scan medication using C5. Sign for meds in C5. - Document medication administration and reaction in QS. - Document reassessment of pain on electronic MAR at appropriate time.	Answer questions.
15. Assess need for delivery "**set-up"**	OB tech may do set-up Keep outside room until delivery imminent.
16. Identify signs and symptoms of 2nd stage. - increased bloody show - expulsive grunt when exhaling - rectal bulging with flattening of perineum - notify provider if not already present.	An RN will be in attendance from full dilation thru recovery.