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HACKETTSTOWN COMMUNITY HOSPITAL

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**MATERNAL SERVICES**
(Scope)

**TITLE**: **COMPLETING THE FORM FOR UNDELIVERED OBSTETRICS PATIENTS**

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PURPOSE: To outline documentation of teaching the undelivered patient how to safely care for her self and fetus upon discharge from Childbirth Family Center after evaluation. To document all teaching done and allow patient a written copy to take with her. To decrease the chances of premature birth.

TARGETED PATIENT POPULATION: Any patient discharged undelivered from Childbirth Family Center after an evaluation.

PERSON RESPONSIBLE: RN discharging patient from Childbirth Family Center

ORDER OF PRIORITY:

A. Reason for visit to Childbirth Family Center
B. Teaching Checklist (1-10)
C. Special Instructions
D. Medication Name (start, dose frequency)
E. Appointment for follow-up care (date)
F. Booklets received
G. Waiver (date, patient signature, staff signature)
H. Addressograph

PLACEMENT: On the back of discharge chart with copy to patient.

CONTENT:

A. Fill in reason for visit per patient care provider's order, not to conflict with admitting.

B. Do patient teaching with checklist.

1. Contractions
   a. Call patient care provider if CXN's every 10 minutes or more often for one (1) hour after one (1) hour of rest.

   b. Menstrual-like cramps, "low" dull backache.

   c. Constant pelvic pressure in your lower back, belly or thigh.

   d. Check CXN's - Lie down on side and place fingers on uterus to feel tightening and softening. Time. Write on paper how far apart and how long they last; bring to hospital.

   e. Intestinal cramping with or without diarrhea.

2. Rupture of Membranes
   a. If you feel any fluid from your vagina, call patient care provider right away.

   b. Put on pad and bring with you.

3. Bleeding
   Any bleeding other than a term patient with a pink, red or brownish tinged show

should call doctor at once, especially if abdominal pain is present.

4. Vaginal Discharge
   a. Sudden increase, foul odor or change to pink or brown.
   b. Use a V-pad; bring to hospital with you.
   c. May become mucousy or watery.

5. Activity
   a. Reducing physical labor and limiting your duties.
   b. Resting, limiting or stopping sex.
   c. Avoiding emotional upsets, worrying and family problems.

6. Increased Swelling, Dizziness, Blurred Vision or Other Visual Disturbances
   a. Especially important to call patient care provider at once with any of above symptoms.
   b. Describe that some swelling in limbs may be normal especially by evening.

7. Decreased Fetal Movement
   a. A general feeling that something is not right even without specific cause.
   b. Record fetal movement; any abrupt decrease or absence of fetal activity for 24 hours should be reported at once.

8. Signs and Symptoms of U.T.I.
   a. Burning or frequency of urination, urgency, suprapubic pain or blood noted in urine.
   b. Explain need for adequate fluids.

9. Fever, Pain
   a. Ask patient if she knows how to take temperature. Chills.
   b. Describe "normal" later pregnancy "pains."

10. Other
    Include any other teaching that was done.

C. SPECIAL INSTRUCTIONS

Write out any special instructions that pertain to patient.

D. MEDICATION

1. Give name, starting time, dose and frequency. Discuss possible side effects.
2. Assist with pharmacy availability.

E. APPOINTMENT FOR FOLLOW UP

If known, give patient appointment day or instruct to call patient care provider's office or HealthStart Clinic.

F. BOOKLETS - GIVE TITLE

1. Located in Childbirth Family Center file cabinet under "Preterm Labor."

2. Titles: "Let's Prevent Preterm Birth" (Gill-Katz), "A Guide for the Woman With Preterm Labor" (Astra), "Premature Labor" (March of Dimes), "Tocolysis for Preterm Labor" and "Tokos" (if M.D. suggests).

G. WAIVER

1. Date, patient signature, R.N. or patient care provider's signature.

2. Give patient her copy and patient care provider's service number if needed.

H. ADDRESSOGRAPH

Stamp form; make sure both copies are legible.

SUGGESTED READING: "Comprehensive Maternity Nursing," (Neeson/May - located in Nursery book shelf). Above pamphlets.

**DISCHARGE PLAN FOR UNDELIVERED OBSTETRIC PATIENT**

Reason for Visit to O.B. Unit:_____

| Teaching Check List | Check |
|---|---|
| 1) Contractions (time, self monitoring, back labor | |
| 2) Rupture of Membranes (note color) | |
| 3) Bleeding | |
| 4) Vaginal Discharge (increase or color change) | |
| 5) Activity (as ordered by Dr., no lifting, avoid upset) | |
| 6) Increased swelling, dizziness, blurred vision | |
| 7) Decreased fetal movement (keep track of) | |
| 8) Signs and symptoms of urinary tract infection | |
| 9) Fever, pain | |
| 10) Other: | |

Special Instructions:_____

_____

Medication Name:_____

Start:_____ Frequency:_____

Dose:_____ Date:_____

Booklets received:_____

Waiver: I understand the above instruction and my medication routine. If I have any questions, I understand I can call the Maternity Unit any time at (908) 850-6888 or my physician. I have received my copy.

_____ _____

DATE PATIENT SIGNATURE STAFF SIGNATURE

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