Section: Division of Nursing

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* **GUIDELINE** *
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Approval: _____

HACKETTSTOWN COMMUNITY HOSPITAL

Originator: R. Mitchell, RN
Reviewed by: C. Burns, RNC

MATERNAL SERVICES
(Scope)

TITLE: OBSTETRICAL HEALTH HISTORY AND ASSESSMENT

PURPOSE: To describe the process for documenting the baseline information about a patient obtained during evaluation in the CFC.

NATURE OF FORM: Permanent & Temporary

TARGETED PATIENT POPULATION: Any patient admitted to CFC (inpatient) and labor checks.

PERSON RESPONSIBLE: RN. May obtain information from patient and/or prenatal history. Information may be asked of patient or support person as appropriate.

ORDER OF PRIORITY: Must be completed during admission process. Indicate NA (not applicable) as appropriate or place slash marks if not appropriate. Every item must be addressed. **Do not leave BLANK boxes.**

DISPOSITION OF FORM COPIES: Duplicate copies of pages 1 and 2 (yellow copies) are to be placed in baby's chart in the history and physical section. Separator sheet to be removed prior to documenting on page 2. If patient is discharged prior to delivery, put white copies with charts to medical records: put Put yellow copies with prenatal record.

PLACEMENT: Once completed, place three white copies in mother's chart in nurse's notes section. Place two yellow pages in baby chart in history and physical section.

CONTENT - PAGE 1:

1. Addressograph bottom left corner.
2. Fill in date and time of admission. Check mode of arrival and where admitted from.
3. Fill in patient's name, name of support person(s) and relationship to patient.
4. Fill in dates and estimated gestational age.
5. Fill in Gravida/Para/Term/Preterm/Abortions/Living. Obtain number from prenatal.
6. Enter blood type from prenatal.
7. Inquire if patient has allergies and document reactions. Fill in NKA (no known allergies) if applicable.
8. Ask patient's height, current weight, pregnancy weight and calculate weight gain.

9. Document FHR and location once EFM is initiated.

10. Fill in vital signs.

11. Indicate if urine specimen was obtained and appearance of urine.

12. Document chief complaint upon admission.

13. Place check mark for reason for admission.

14. Fill in vaginal exam results at admission by nurse or health care provider; or results if done in office. Check "Deferred" if not done at admission.

15. Fill in date and time of onset of contractions; inquire if patient has pain or discomfort with contractions (see#17); assess frequency and duration of contractions; ask patient if she has any vaginal bleeding.

16. Place checkmark to indicate membrane status with date, time and color if SROM has occurred. Circle nitrazine positive or negative if test used.

17. Ask patient to rate pain of contractions on scale 1-10 and circle number.

18. Ask patient if she participated in classes and place check mark as appropriate. Indicate if patient took with first pregnancy. Ask if patient plans to breastfeed, bottlefeed or both. Discuss anesthesia and indicate as appropriate. Fill in pediatrician's name.

19. Place check marks to indicate prenatal care and availability of prenatal records (prenatal records should be available in CFC by 36 weeks gestation). Fill in dates of LMP and first prenatal visit. Check off any tests that patient had during prenatal period. Document if any obstetrical issues occurred during prenatal period.

20. Obtain information from prenatal history and check off status of bloodwork as appropriate and fill in dates. May ask pt for GBS status but it must be verified with health care provider.

21. Document any surgeries, illnesses or hospitalizations that pt may have had. Ask if the pt has been exposed to contagious diseases and document results.

22. Fill in date(s) and type of previous deliveries if applicable.

23. Place check mark for any medical condition experienced by pt and document appropriate treatment/comments/dates.

24. Place initials and signatures of registered nurses that obtain history as well as date and time of completion of form.

CONTENT – PAGE 2:

1. Ask pt if she is taking any medications including but not limited to: PNV, herbs, over the counter medications, and insulin. Document name, dosage amount, time of last dose and usual time that pt takes medication.

2. Document use of tobacco, alcohol or recreational drugs along with amount per day, number of years used, frequency, quit date or if pt attended rehabilitation. Verify with prenatal history. Document by writing DENIES if applicable.

3. Circle level of consciousness and ADL level. Circle if pt complains of headache or dizziness. Circle if vision is WNL or if pt uses eyeglasses or contacts and if they are in place. Circle if hearing is WNL or impaired or if hearing aid is in place. Circle if speech is WNL or if an interpreter is needed. Ask pt if any family member has tested positive for childhood hearing loss and check yes or no.

4. Assess, edema, respirations and cough, if any, and check off or fill in results.

5. Circle if GI findings. Fill in date of last bowel movement. Check off if any GU difficulties.

6. Fill in date and time of last oral intake. Ask about usual diet and any special dietary requests. Be sure to enter requests in Affinity system clinical circumstances. Check off if pt has dentures, bridges or braces in place.

7. Check if skin is intact or not; document and check off findings.

8. Assess musculo/skeletal systems, back problems, and joint pain. Ask if any assistive devices are necessary. Check off as appropriate.

9. Check if pt is candidate for falls program. Document on page 3 Patient Care Notes if necessary.

10. Inquire if pt has had any chronic pain that is not related to the admission. Check off type, duration, ask for intensity on scale 1-10 and ask what relieves the pain. Circle pain rating number. If pt. denies pain, circle “0”.

11. Ask pt if they have an advanced directive-explain the document. If pt requests information, mark yes and contact patient representative for further information.

12. Fill in primary language and if a translator is required. Ask for religion and occupation. Check off marital status and note if Father of Baby is involved. Fill in who pt lives with. Check off/fill in if others depend on pt and if they have any cultural/spiritual needs.

13. Discuss with pt their knowledge level. Check off as indicated by assessment.

14. Check off if pt has any of the barriers to learning listed. Make note as needed.

15. Ask pt directly about abuse. Check off as appropriate. Contact social services as required (see page 3 item 5). A statewide toll free number is 1-(800)-572-7233. A local NJ number is 1-(973)-759-2154. They are listed in Rolodex.

16. Ask if the pt has anything to place in hospital safe. If yes, identify and use HCH Valuables envelope found in narcotics cabinet closet. Have pt sign form.

17. Place initials and signatures of registered nurses that obtain history, fill in dates and time of completion.

CONTENT – PAGE 3:

1. Check off as items are discussed with pt and completed.
2. Check off ‘Preop teaching done” when form is completed during PAT’s for scheduled Cesarean sections.

3. Use pt care notes section to explain any item (i.e. Page 2 item 10 – Chronic Pain Assess: Pt states she goes to Physical Therapy).
4. Ask if car seat is available or if supplies are needed. Discuss use of car seat. Fill in anticipated date of discharge depending on reason for assessment. Fill in address and phone number of intended destination if other than home. Ask if pt has support after

discharge. Note if discharge planner needs to be contacted.

5. Ask if needs are met. Mark yes if there are no problems.

6. Check off areas if referrals are necessary upon admission assessment. Contact health care provider or make referral and fill in who was notified as well as date and time. Person calling referral should sign and date. Nutrician services should be checked if the patient plans on breastfeeding. Social Services should be checked if patient is a Healthstart Clinic Patient, if no prenatal care, or if patient is under 18 years old and other reasons may be applicable. Check “none” as applicable.