PMH
MEDICAL CENTER

Policy: ADMISSION TO INPATIENT OB PROCEDURE

Policy Number: 701-0009

Effective: 09/01/02 **Audit Review: 03/04/15**

POLICY

PURPOSE: **A Perinatal Registered Nurse will perform assessment and direct the antepartum, intrapartum and postpartum care management of women experiencing pregnancy and childbirth.**

SUPPORTIVE DATA

-EFM Protocol

-Documentation Guidelines

-Standard Precautions

-Urine testing for protein

-Infant Security

SUPPLIES

-CPSI charting access for Outpatient OB, Initial Interview, Admission Assessment, Labor Flowsheet

-Specimen cup, clean wipes

-EFM

-Floor scale, Thermometer, B/P cuff, Stethoscope

-Patient gown and monitor belts

STEPS

1. Escort woman to triage or labor room. Weigh on floor scale. Instruct her to obtain clean catch urine, remove personal clothing, and don hospital gown. Provide bag for personal items if needed.

2. Orient to room, nurse call, bathroom, routines, and plans for care.

3. Do not leave alone in presence of frequent and strong contractions, pelvic pressure, or extreme anxiety.

4. Review procedures for woman concerning her progress through labor management.

5. Review prenatal history.

   - Obtain Blood type and Rh factor, VDRL status, Hepatitis screen, Rubella titer, GBS status. Determine Gravity, Parity, and EDC. Confirm Allergies and coexisting medical conditions.

6. Place EFM to begin baseline and /or ongoing assessment of fetal heart rate and uterine activity. Routine 30-minute strip on admission.

7. Perform Vaginal exam if indicated

   a. Do not perform vaginal exam in presence of heavy vaginal bleeding or preterm labor
   b. Update physician on status and obtain orders.
   c. Determine cervical status, status of membranes

8. Complete Outpatient OB Patient on CPSI and determine disposition. Admit to labor, or discharge to home per Dr's order.

9. Determine educational needs for woman during labor management, delivery and postpartum care and newborn care and breastfeeding.

10. Initiate routine labor/delivery management orders and protocols, or other orders as indicated by Healthcare provider.

11. Determine expected outcomes and initiate plan of care

DOCUMENTATION

12. Document exceptions, reportable concerns, and patient responses in the medical record. Include all communications with the health care provider.