PMH MEDICAL CENTER

Policy: ADMISSION ASSESSMENT OF THE LABOR PATIENT

Policy Number: 701-0025

Effective: 11/11/08 **Audit Review: 03/04/15**

POLICY

1) Qualified personnel should collaboratively provide care for patients during the initial assessment of the obstetrical patient.
2) Labor patients should be assessed and the provider notified promptly of the patient's arrival to Family Birth Place and status of patient by the Labor and Delivery RN.
3). Assessment should include, but not be limited to the following:
   1. Maternal physical status
   2. Fetal status
   3. Labor status
   4. Psychosocial needs
   5. Review of prenatal records
   6. Patient interview; including chief complaint.

PROCEDURE

1) Receive patient. Instruct patient to remove street clothes and don hospital gown, with no under garments. Obtain clean catch urine sample if possible.

   Supplies needed:
   1. Fetal monitor, ultrasonic gel, and 2 monitor belts
   2. Prenatal record from file drawer in nurse's station.
   3. Scales, BP cuff, stethoscope, thermometer
   4. Urine specimen cup
   5. Sterile gloves, sterile lubricant
   6. Patient gown and underpad

2) Assess and document maternal status on CPSI computer charting, *'L&D: Initial Interview & Discharge Plan'* flowchart. If assessment leads to admission, continue documentation with 'L*&D: Labor and Delivery'* flowchart.

   1. Patient's chief complaint or description of symptoms
   2. Date and time of arrival
   3. Gravidy and parity
   4. Vital signs, height and weight
   5. Estimated date of delivery determined by dates and ultrasound
   6. Vaginal bleeding including date, time, duration, & associated events
   7. Pregnancy risk factors
   8. Current medications

9. Allergies
10. Time of last meal and fluid intake
11. Physical assessment

3) Assess and document in 'L&D: Labor and Delivery' flowchart fetal status:

1. Fetal movement
2. Fetal heart rate obtained by auscultation or electronic fetal monitoring upon admission for 20 minutes or until appropriately reactive strip for gestational age is obtained.

4) Assess and document in 'L&D: Labor and Delivery' flowchart labor status:

1. Uterine contractions including date and time of onset
2. Palpate abdomen for tenderness, uterine contractions, and resting tone.
3. Membrane status including date and time of rupture, color of amniotic fluid.
4. If no history of prematurity, rupture of membranes, vaginal bleeding, or placenta previa proceed with sterile vag examination to include dilation, effacement, position, and consistency of cervix.
5. Repeat cervical examination as indicated to assess for change.

5) Assess and document in 'L&D: Initial Interview & Discharge Plan' flowchart as well as 'L&D: Labor and Delivery' flowchart psychosocial needs:

1. Labor plan
2. Significant stress
3. Relationship problems
4. Economic problems
5. Education level and needs
6. Support systems
7. Cultural and religious needs
8. Substance abuse
9. Nutritional status
10. Functional status
11. Abuse
12. Power of Attorney

6) Notify patient's OB provider of initial assessment within 30 minutes of admission. Including any significant abnormal findings and review of patient's prenatal record Receive physician orders for labor management.

7) Provide continuous education and care for the patient and fetus as the labor progresses. Communicate with the physician as labor progresses, receive and carry out orders as the labor progresses.

8) Prepare for the care of the infant.