# Maternal Post Cesarean Section Recovery Record

**Patient Identification**

- **Delivery:**
- **Date / Time:**
- **Sex:**
- **Weight:**
- **BR:**
- **BT:**
- **Admitting Nurse:**
- **Date / Time:**

**Type of Anesthesia:**

**Accompanying Member of Anesthesia:**

## Vital Signs

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>BP</th>
<th>Temp</th>
<th>Pulse</th>
<th>Resp</th>
<th>Loc</th>
<th>Color</th>
<th>Skin</th>
<th>ABD DSG/Incision</th>
<th>EKG</th>
<th>O₂</th>
<th>O₂ Sat</th>
<th>Position</th>
<th>Sensory Level</th>
<th>Motor Funct’n</th>
</tr>
</thead>
</table>

**Assessments**

- **Sensory Level**
- **Motor Function**

**Initials:**

**Nurse’s Signature / Title:**

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**Part of the Medical Record**
## Maternal Post CESAREAN SECTION Recovery Record

### Allergies:

### Recovery I/O Totals:

<table>
<thead>
<tr>
<th>Shift #1</th>
<th>Shift #2</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intake:</strong></td>
<td><strong>Output:</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Assessments

<table>
<thead>
<tr>
<th>Bladder PALP</th>
<th>Urine COLOR</th>
<th>Urine CHAR</th>
<th>IV SITE</th>
<th>FUNDUS</th>
<th>LOCHIA</th>
<th>PERINEUM CHG</th>
<th>PERICARE</th>
<th>PAD CHGD</th>
</tr>
</thead>
</table>

### Intake

<table>
<thead>
<tr>
<th>Mainline IV TYPE</th>
<th>AMT</th>
<th>Mainline IV TYPE</th>
<th>AMT</th>
<th>Mainline IV TYPE</th>
<th>AMT</th>
<th>P.O.</th>
</tr>
</thead>
</table>

### Initials:
- Patient
- Nurse’s Signature / Title

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**Part of the Medical Record**

8850437 Rev. 05/05
Maternal Post C-Section Recovery Record_MIH

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# Maternal Post Cesarean Section Recovery Record

<table>
<thead>
<tr>
<th>NURSING NOTES</th>
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</tr>
</thead>
<tbody>
<tr>
<td>TEDS ON:</td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>SCUDS ON:</td>
<td></td>
</tr>
<tr>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPUT</th>
<th>TEACHING</th>
<th>INIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>URINE</td>
<td>EMESIS</td>
<td>OTHER</td>
</tr>
<tr>
<td>CODES</td>
<td>RESPONSE</td>
<td>INIT</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INITIALS:</th>
<th>NURSE’S SIGNATURE / TITLE:</th>
</tr>
</thead>
<tbody>
<tr>
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<td>NURSE’S SIGNATURE / TITLE:</td>
</tr>
</tbody>
</table>

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**PART OF THE MEDICAL RECORD**
### MATERNAL POST CESAREAN SECTION RECOVERY RECORD

**PATIENT IDENTIFICATION**

**PAIN MANAGEMENT RECORD**

<table>
<thead>
<tr>
<th>PAIN SCALES:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>WONG-BAKER:</strong> (Faces)</td>
</tr>
<tr>
<td><strong>0-10 VISUAL:</strong> (Numeric)</td>
</tr>
<tr>
<td><strong>VERBAL:</strong> No Hurt, Hurts Little Bit, Hurts Little More, Hurts Even More, Hurts Whole Lot</td>
</tr>
</tbody>
</table>
| **NON-COGNITIVE:** Flacc Score (very painful)

**FLACC Score**:

1. Sum FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY
2. Record FLACC Score w/ 0-10 Numeric Scale above.

**COMFORT GOAL:**

**PAIN RATING SCALE USED:**

**MEDICATION ADMINISTRATION RECORD**

<table>
<thead>
<tr>
<th>DATE</th>
<th>TIME</th>
<th>MEDICATION</th>
<th>DOSE</th>
<th>ROUTE</th>
<th>SITE</th>
<th>INIT’LS</th>
</tr>
</thead>
</table>

**INFUSION RECORD**

<table>
<thead>
<tr>
<th>DATE UP</th>
<th>TIME UP</th>
<th>IV SOLUTION</th>
<th>AMOUNT UP</th>
<th>RATE</th>
<th>NURSE INIT’LS</th>
<th>DATE DOWN</th>
<th>TIME DOWN</th>
<th>NURSE INIT’LS</th>
<th>CON’T. PUMP (/)</th>
<th>AMOUNT WASTED</th>
</tr>
</thead>
</table>

**LABORATORY REPORTS**

<table>
<thead>
<tr>
<th>Date / Time Drawn</th>
<th>WBC</th>
<th>HGB</th>
<th>PLTs</th>
<th>PT</th>
<th>PTT</th>
<th>Prothrombin</th>
<th>D-Dimer</th>
<th>GLU</th>
<th>BUN</th>
<th>NA</th>
<th>K</th>
<th>CL</th>
<th>CO2</th>
<th>CR</th>
<th>Alb</th>
<th>Prot</th>
<th>Tot Prot</th>
<th>Mg</th>
<th>++</th>
</tr>
</thead>
</table>

**URINE RESULTS**

<table>
<thead>
<tr>
<th>TIME</th>
<th>INITIALS</th>
</tr>
</thead>
</table>

**PART OF THE MEDICAL RECORD**
MATERNAL POST CESAREAN SECTION RECOVERY RECORD

PATIENT IDENTIFICATION

ASSESSMENT CODES (Requires a NURSING NOTE)

LEVEL OF CONSCIOUSNESS OR SEDATION RATING:
- S - Normal sleep, easy to arouse, oriented when awakened, appropriate cognitive behavior
- 1 - Wide awake-alert (or at baseline), oriented, initiates conversation
- 2 - Drowsy, easy to arouse, oriented & demonstrates appropriate cognitive behavior when awake
- 3 - Drowsy, somewhat difficult to arouse, but oriented when awake
- 4 - Difficult to rouse, confused, not oriented
- 5 - Unarousable

POSITION:
- Lat - Left Lateral
- Supine
- Semi-Fowlers
- Trendelenburg
- High-Fowlers

PERINEUM:
- I - Intact
- Y - Yes
- N - No
- SF - Semi-Fowlers
- HF - High-Fowlers

SENSORY LEVEL:
- T4 - Nipple*
- T6 - Xiphoid*
- T8 - Lower Ribs
- T10 - Umbilicus
- T12 - Lower Abdomen

URINE ASSESSMENT:
- O - Site without redness, swelling, induration
- Symptomatic*
- Sediment
- Clear
- Cloudy
- Intact

IV CODES:
- O - Site without redness, swelling, induration
- Symptomatic*
- Sediment
- Clear
- Cloudy
- Intact

PAD CHANGE:
- P - Peripad changed
- I - Chux changed

PAIN MANAGEMENT INTERVENTIONS:
- 1 - Discuss pain management plan with physician
- 2 - Pharmacological
- 3 - Non-Pharmacological
- A - Position change
- B - Music

TEACHING CODES:
- 1 - Room Orientation
- 3 - Postoperative Care
- 5 - PCA
- 7 - Breastfeeding
- 9 - Security Measures
- 11 - Wound Care

REGIONAL ANESTHESIA:
- Temp: Initially, every hr x 4 hrs; then every 4 hrs.
- BP, P, R: Initially; make sure IV site is secure, and upon discharge.
- Skin Color / Condition, LOC, IV Site: Initially; PRN if changes; and upon discharge.
- EKG & Oxygen Sat, Fundus, Lochia, Perineum: Initially; every 15 min x 4; then every 30 min x 2; then every hr x 2; then every 4 hrs (EKG & Pulse Oximetry may be discontinued after 1 hr if stable).
- Oxygen: When started, changed or discontinued
- Motor Function / Sensory Level: Initially & every hr until returning to patient baseline.
- Complete Post Anesthetic Score

GENERAL ANESTHESIA:
- Constant bedside surveillance: for at least 30
- BP, P, R, LOC, Color, EKG & O2 Sat: Initially and every 5 min x 6 (stable patient may be transferred or have EKG & pulse ox dc'd); every 30 min x 2; then every hr x 2; then every 4 hrs until transferred.
- Temp, Skin, Abd, Dsg, Fundus, Lochia, I&O: Urine color and character, pericare / pad change, IV site, oxygen as per regional anesthesia.

EKG STRIPS:
- For all C-Section Patients: Print a strip (6 seconds) at beginning of recovery period and at the end. Also, print a 6 second strip anytime the pattern changes. Place all strips in the designated area.

STANDARDS OF CARE: Cesarean Section Delivery

PAIN MANAGEMENT:
- Initially, before and after interventions, and prior to transfer (see hospital standard - pain assessment to be documented at least every 8 hrs).

PART OF THE MEDICAL RECORD
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>SpO₂ &gt; 95% Room Air</td>
<td>2</td>
</tr>
<tr>
<td>SpO₂ &gt; 95% with O₂</td>
<td>1</td>
</tr>
<tr>
<td>SpO₂ &lt; 95% with O₂</td>
<td>* 0</td>
</tr>
<tr>
<td>Spontaneous Resp. Airway</td>
<td>2</td>
</tr>
<tr>
<td>Spontaneous Resp. Airway</td>
<td>1</td>
</tr>
<tr>
<td>Respiratory Support Required</td>
<td>* 0</td>
</tr>
<tr>
<td>SBP ± 20mmHg Pre Op</td>
<td>2</td>
</tr>
<tr>
<td>SBP ± 20-50mmHg Pre Op</td>
<td>1</td>
</tr>
<tr>
<td>SBP ± 50mmHg Pre Op</td>
<td>* 0</td>
</tr>
<tr>
<td>Aware of self &amp; surroundings</td>
<td>2</td>
</tr>
<tr>
<td>Arousal on Calling</td>
<td>1</td>
</tr>
<tr>
<td>Unresponsive to Mild Stimuli</td>
<td>* 0</td>
</tr>
<tr>
<td>Moves 4 Extremities on Command</td>
<td>2</td>
</tr>
<tr>
<td>Moves 2 Extremities on Command</td>
<td>1</td>
</tr>
<tr>
<td>Moves 0 Extremities on Command</td>
<td>0</td>
</tr>
</tbody>
</table>

**TOTAL:**

**DISCHARGING NURSE / TITLE / TIME:**

**REPORT TO UNIT NURSE:**