Post Critical High Risk Antepartum

Signature	Title	Initial

Signature Requiring Co-Signature	Date/Shift	Initial/Title

ADDRESSOGRAPH

DESIRED OUTCOMES — **D = DAYS E = EVENINGS N = NIGHTS**

Problem/ Needs	Day ____ GA _____ Date: _____	N	D	E	Problem/ Needs		N	D	E
Knowledge Deficit related to plan of care	Patient/family verbalizes understanding of treatment plan, diet, medications, and activity; participates in decision making / plan of care.				Alterations in ADL's / Activity due to:	Able to perform ADL's with: ____ assistance ____ independently			
						Physical Therapy Functional Screen completed for planned BR>4 days			
Fetal Well Being	NST Reactive								
	FHR Baseline								
	N								
	D								
	E								
Maternal Well Being	Vital Signs / Temperature WNL				Anxiety / Fear related to High Risk Pregnancy Outcome	Able to express / verbalize feelings of fear / anxiety.			
	Decrease / absence of vaginal fluid leakage / bleeding.					Significant other expresses interest and involvement in decision making.			
	Verbalizes understanding of how to detect / count fetal movement.								
	Verbalizes individual sleep needs being met.				Discharge Planning				
	Weight appropriate.								
	Homan's sign negative								
Pain Management	Pain free or verbalizes relief after intervention.				Patient Safety	Remains injury free in a safe environment.			
	States < 3 contractions per hour or states decrease in abdominal cramping/ contractions. States decrease or absent intermittent thigh, back, abdominal or pelvic pain.					ID bracelet on			
					Skin Integrity	No evidence of skin breakdown.			
					Patient/Family Satisfaction	Patient/family verbalizes satisfaction with hospital stay/care.			

INTERVENTIONS (continued on back)

Patient Care Categories		N	D	E	Patient Care Categories		N	D	E
Discharge Plan (1)	Assess need for changes in Discharge Plan and communicated to patient/ family.				Nutrition (2)	* Diet: Encourage / provide fluids			
						% of diet consumed:			
						Breakfast _____ %			
						Lunch _____ %			
						Dinner _____ %			
						High risk nutritional assessment completed.			

** indicates medical orders needed*

INTERVENTIONS (continued) MR# _____

Patient Care Categories	*Day ____ GA _____ Date: _____*	*N*	*D*	*E*	*Patient Care Categories*		*N*	*D*	*E*
Assessment & Treatments (3)	Assess q ___ hrs. while awake: - Vital Signs & BP - Vaginal Discharge - Breath Sounds - Homan's Sign (q24) - Emotional status / coping mechanism - Review plan of care				***Teaching & Psycho-social*** (4)	Assess patient / family satisfaction.			
	I & O q shift.					Encourage verbalization of fears / concerns.			
	* TED's (if on complete bedrest) remove daily					Learning needs / teaching plan: _____ _____ _____ _____ _____ _____			
	* IV insertion if ordered					MFM Consults			
	IV / PIID: _____ Site: _____					Encourage patients in diversional activities.			
	* EFM q: _____								
	* Specimen Collection								
	Linen change / HS Care Comfort Care PRN				***Specimens & Diagnostics*** (5)	Lab / diagnostics results reviewed; MD notified if indicated.			
	* Special Procedures/specimens Type: _____ _____ _____ _____ _____ _____					* Tests / Procedures _____ _____ _____ _____ _____ _____			
	Weight weekly on Monday								
					Safety & Activity (6)	* Activity level:			
						Functional Screen for planned BR>4 days			
						Physical Therapy Consult for Pre-existing neuromuscular disorder			
						Exercize program designed by PT, completed by patient			
						Bladder / bowel with assist for complete bedrest			
						Showers.			
						Bathes self with assist.			
Priority of Care						Transport by staff.			

** indicates medical orders needed*