THE UNIVERSITY OF NORTH CAROLINA HOSPITALS
Nursing

PATIENT CARE PLAN

Initiated: Date: _____ Time: _____ R.N. _____

Imprint each page

Patient Care Plan for: **Antepartum Complications**

Problem Activated Date/Time Signature	Problem Resolved Date/Time Signature	Focus/Problem	Outcome - The Patient will:	Applicable Interventions/Plan • *Document Implementation of protocol in PCR/Flowsheet* • *Document Outcomes in Progress Notes*
		1. Alteration in maternal/fetal physiologic state as evidenced by: -insufficient utero-placenta perfusion related to hypertension in pregnancy or mal-aligned placenta -potential for injury related to PTL/PROM hyper/hypoglycemia -maternal infection -active labor -hyperemesis -surgery	Demonstrate: -<4 contractions/hour -absence of, or no increased, vaginal bleeding -serum glucose 80-120mg/dl -temp. <37.6 °C -reduced emesis The fetus will demonstrate -FHR=120-160bpm -Activity and/or >4 kicks per hour	1. Assess patient q 8 hours for: -uterine contraction -fetal activity (>24 weeks gestation) -fetal heart rate (>24 weeks gestation) NOTE: Assess fetal activity and fetal heart rate daily for > 12-23 weeks gestation). -vaginal discharge -adherence to activity restrictions 2. Assess T,P,R,BP bid. 3. Document external fetal monitoring on External Fetal Monitoring Flow sheet and patient care record. 4. Implement Monitoring: Maternal/Fetal: Antenatal Patients protocol. 5. Implement Preterm Labor/Premature Rupture of Membranes Protocol. 6. Implement Hypertension in Pregnancy [Antepartum Unit] 7. Implement Pregnancy and Diabetes Protocol. 8. Implement Hyperemesis Gravidarum Protocol. 9. Implement Placenta Previa: Antepartum Unit Protocol. 10. Implement Pyelonephritis in Pregnancy Protocol. 11. Implement Post-op Management Protocol. 12. Implement Balloon, Foley Catheter: Cervical Ripening/Induction of Labor Using Extraaminotic Placement. 13. Transfer to L&D when in active labor. 14. Notify M.D. for non-reassuring FHR. 15. 16.
		2. Anxiety R/T: -hospitalization -alterations in family dynamics -maternal/fetal health risks	Demonstrate decreased anxiety when she is able to: -Identify ways to cope with: a. hospitalization b. separation from family -Participate in the development of plans for maternal/fetal care -Participate in care -Accomplish tasks of pregnancy	1. Encourage expression/discussion of fears and concerns. 2. Encourage/support family interactions (visits, calls). 3. Assist with diversional activities. 4. Assess patient's accomplishment of tasks of pregnancy: -acknowledge pregnancy -accept baby (fetus) as real -prepare for baby (name, supplies) 5. Initiate referrals e.g.: chaplain, social worker, teacher (Hospital school) _____ _____ 6. 7.

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		3. Alterations in comfort R/T physiologic changes of pregnancy.	Demonstrate acceptable comfort within one hour of intervention as evidenced by: -nonverbal behavior -verbalization of decrease in pain scale score	1. Implement Pain Management Protocol. 2. Reassure patient if discomfort is the result of normal physiology of pregnancy. 3. 4.
		4. Altered nutrition/fluid intake less than body requirements secondary to increased needs of pregnancy.	Have adequate dietary intake as evidenced by: -consumption and toleration of at least 50% of food provided on each meal tray -Maintain or increase body weight 2-3 lbs/month -Drink ≥2000mL of fluid per day	1. Monitor meal intake to insure consumption/tolerance of at least 50% of diet. 2. Encourage fluid intake of ≥2000mL/day. 3. Initiate dietitian referral. 4. Weigh weekly (Wednesday) or per designated protocol. 5. Document/notify M.D. if unable to tolerate diet/fluids. 6. 7.
		5. Knowledge deficit R/T: -maternal/fetal complications -labor and delivery -physiology of pregnancy -plan of care	Verbalize or demonstrate knowledge of: -complications(s) diagnosed -potential risks to self/fetus -treatment plan -labor and delivery -physiology of pregnancy	1. Assess and document knowledge base and level of understanding of patient and/or caregiver. 2. Assess and document barriers to learning and readiness for learning. 3. Provide explanation of all procedure/medications prior to implementation. 4. Document patient/caregiver response to teaching and further learning needs on OB Patient Care Record daily. 5. 6.

06/16/92, 01/99,
12/18/01, 11/9/04, 12/21/04
RL #55

Reference: Lowdermilk, D.L., & Perry, S.E. (2004). *Maternity & Women's Health Care. (8th ed.).* St Louis: Mosby.