Beebe Healthcare
Margaret H. Rollins School of Nursing
Nursing 202 - Advanced Concepts of nursing
Multidisciplinary Care Map - template
2024

S	**Situation:** 1. L.B., 35 y/o, FIN 87059176 2. Delivery of singleton 3. 03/28/2024 4. 03/29-30/2024 (Night shift on the 29th) 5. Induction of labor on 3/28 followed by urgent C-section due to non reassuring fetal heart tones and failure to progress.
B	**Background:** 1. PMH: Anxiety, depression, Migraines, Tachycardia, PTSD, Bipolar 2 disorder, anemia; Surgical hx includes wisdom teeth extraction; Full code. 2. Gestational hypertension 3. Admitted to OB unit on 3/28 at 0818 for induction of labor and put on fetal monitor showing moderate variability and x1 early decelerations, 1cm dilated. At 1242 had SROM; BP 142/99; still showing occasional decelerations and moderate variability, 2cm dilated. At 1722 BP 127/88; presenting with occasional early and variable deceleration with moderate variability, 4cm dilated/ 80% effaced; continuing oxytocin titration PRN. At 1716 BP 130/75; new onset of late decelerations- IV bolus given, oxytocin off and O2 10L via face mask given. IUPC and FECG applied, 5cm dilated/90% effaced. At 1900 amnioinfusion started for recurrent variables; pt comfortable with epidural; BP 144/91. Primary low transverse C-section was recommended at 2308 for non reassuring fetal heart tracing and arrest of dilation in the latent phase. C-section performed at 0058 on 3/29 by A. Nyanin; EBL 800mL, foley catheter in place with 700mL of UO; C-section performed with no complications. 3/30- postpartum day 1; complaint of blurry vision during night following C-section- resolved in am; fundus firm and nontender, incision is clean/dry/intact, lochia discharge remaining WNL, BP 122/78. 6/10 pain controlled with 5 mg oxycodone and 650 mg acetaminophen. Needing constant reminding for appropriate feeding times q2hr. 4. Current treatments: a. No diagnostic studies were performed. b. Labs- Post C-section: 3/30- (0523) Hgb: 9.6 (Low)/Hct: 31.0 (Low)/Plt: 122 (Low), Rationale- due to 800mL blood loss during C-section and hx of anemia. (0944) Hgb: 9.5 (Low)/Hct: 30.2 (Low)/Plt: 121 (Low), Rationale- Healing from delivery of fetus and surgical incision and history of anemia. (1625) Hgb: 9.3 (Low)/Hct: 30.7 (Low)/Plt: 121 (Low), Rationale- Post op <24

	hours C-section delivery and history of anemia. c. Ibuprofen 800mg PO q8hr for post-op delivery pain, acetaminophen 650mg PO q4hr for post-op delivery pain, simethicone 160mg PO q6hr for abdominal gas, oxycodone 5mg PO q6hr for 7/10 pain, oxytocin 500mL at 100mL/hr after delivery to help uterine contraction and aid in risk for bleeding (administered when IV was still patent) d. Abdominal binder PRN, OOB with assistance
A	**Assessment:** 1. A&Ox4, lung sounds clear and equal bilaterally/ unlabored; RR 18, heart rate 109, regular rhythm, BP 122/78, abdomen is nontender and bowel sounds present in all four quadrants; fundus is midline and firm, extremities have some tenderness with +1 edema around the ankles. Temp 36.9 C; Incision site is well approximated with steri strips covered by gauze; clean, dry, intact; reporting no pain, pallor, edema, erythema or discharge. LB is tolerating a regular diet and reporting epigastric pain. Lochia discharge is WNL of scant amount of rubra blood. Urine output WNL at >30mL/hr; no difficulties voiding. Reporting abdominal pain 7/10 and requesting "smaller dose of oxycodone to not be too drowsy to breastfeed". Received acetaminophen 650mg, ibuprofen 800mg, and simethicone 160 mg 6 hours after administration of oxycodone due to no relief of pain. Reevaluated and stated pain was much better after receiving medications. Attempting to breastfeed q2hr and when reminded by RN. Ambulating to the bathroom with minimal assistance when needing to void. 2. A. Nyanin labor progress notes: (0823) patient doing well, denies headache and pain with contractions. (1423) patient doing well, mild cramping with contraction, SROM 1242. (1803) Fetus showing moderate variability, cervix 4/80/-1. (1831) New onset of late decelerations, cervix 5/90/0, IUPC and FECG applied. (2134) Comfortable with epidural. (2308) evaluated patient due to prolonged fetal heart rate deceleration. A. Nyanin delivery note: Primary low transverse C-section; delivered a boy at 0021 on 3/39; EBL 800mL, UO 700mL via foley catheter; no complications were documented during the C-section. 3. Priority nursing problems: a. Risk for bleeding i. Rationale: In the postpartum period post op from urgent C-section. Diagnosis of gestational hypertension with frequent high blood pressures during labor period and anemia. b. Readiness for enhanced breastfeeding i. Rationale: Needing frequent reminders when to breastfeed at the beginning of the shift. Educated about feeding cues baby could be presenting with if hungry. Was breastfeeding q 2 hours and recording start/end time on breastfeeding paper by the end of shift. c. Acute pain: Abdomen

	i. Rationale: Less than 24 hours post op C-section with a transverse abdominal incision. The uterus is healing from delivery of the baby. 4. Interventions performed: a. Educated about the importance of watching for feeding cues the baby may be presenting whenever hungry. Also educated that it is recommended to feed the baby every 2 hours, but also anytime presenting with hungry cues, even if still in the 2 hour window. Rationale: Education is important for first time parents on what to expect when feeding their baby and how to see if they are hungry. Helping with breast feedings can reduce anxiety upon leaving the hospital to ensure the baby is eating and latching correctly. b. Administered oxycodone 5 mg PO. Rationale: Reporting abdominal pain 6/10. No IV access during my shift due to infiltrated IV that was caught and discontinued during the previous shift. c. Performed fundal check. Rationale: To confirm placement and tone of the fundus due to increased risk for bleeding during the postpartum period. d. Assisted with ambulation to the bathroom. Rationale: To ensure the patient is stable on feet while ambulating around the room without assistance from RN at bedside. Also educated about slowly getting out of bed to prevent orthostatic hypotension and what to do if feeling dizzy upon standing up.
R	**Recommendation:** 1. Risk for bleeding: a. LB will have a scant amount of lochia rubra q6hr during my time of care. b. LB will have a BP 110-130/70-90 and HR of 60-100 during my time of care. 2. Readiness for enhanced breastfeeding: a. LB will breastfeed q2hr or when the baby is presenting with feeding cues during my time of care. b. LB will be encouraged to ask any questions to the lactation consult or RN regarding breastfeeding prior to discharge. 3. Acute pain in abdomen: a. LB will keep up with pain control by letting RN staff know when feeling onset of pain during my time of care. b. LB will ambulate having one standby assist around the room and to the bathroom during my time of care. 4. No consults were recommended. 5. No tests or treatments were recommended. 6. Discharge needs should include further education about the importance of feeding times for newborn/infant stage. Also, the importance of knowing the signs and symptoms of postpartum depression and knowing who to

	talk to when feeling the need to report the feelings before a detrimental event occurs (like shaken baby or self harm). 7. Resources that would be beneficial for LB are taking advantage of the six outpatient appointments that are available as needed for new moms through insurance. Another resource that should be given to LB is education about postpartum preeclampsia due to the elevated blood pressures throughout pregnancy and the labor period.

Evaluation of Care:

1. Interventions including pain medications (oxycodone and acetaminophen), repositioning frequently/getting up to ambulate, and educating on feeding q2hr/ attempting to use a nipple shield worked well.
2. Since the start of shift, LB has improved. Pain levels decreased to a tolerable level, not needing to be controlled by medication. By the end of shift, she was feeling (attempting to use a nipple shield), without needing a reminder from nursing staff. She is also able to ambulate to the bathroom having a standby assist from RN or husband.
3. LB status at the end of shift was staying in the hospital for another 24 hours to receive more maternal/newborn care and projected to be discharged on 3/31.
4. The previously stated goals were met by LB during my time of care. She was able to ambulate by herself around the room and to the bathroom with husband assisting. She was also very interested in participating in care of the newborn during my shift.
5. During my shift, LB's patient problems had remained the same. Acute pain is an expected problem post surgery and delivery but will gradually decrease in the following days. LB is still at risk for bleeding for up to 12 weeks after delivery. Prior to the end of my shift LB has improved with her breastfeeding tactics after being further educated on the many important factors. She is in a position to continue enhancing her breastfeeding skills after being discharged.

- Identify the multidisciplinary team members involved in the care of your patient. Include the role they had in providing care.