IM6 (OB) Critical Thinking Worksheet

Student Name: Shallas Taylor **Date:** 2/7/24

1. Diagnosis: Fetal intolerance IUGR

Admission Date and Time: 2/6/24 @ 2123

Age: 18 **Race:** Hispanic **Marital Status:** single

Allergies: NKDA

LMP: 5/18/23

EDD: 2/22/24 **Prenatal Care:** yes

2. Delivery Information:

Delivery Date and Time: 2/7/24 @ 0442

Vaginal/(C/S): **If C/S, reason:** Fetal intolerance 2 min decel

Incision or Lacerations: low lying transverse

Anesthesia/Analgesia in L & D: lidocaine/epidural

BTL: Ø **Quantitative Blood Loss:** 400mL

Gestational Age at Delivery: 37 weeks 6 days

3. Maternal Information:

Foley: 16F **Voiding Past Removal:** NOT yet removed

IV: (L) H 18G **V/S:** 98 temp, 112 pulse, 18 R/R, 139/89 BP, 97%

Activity: Bed rest until 1300 **Diet:** liquid → it tolerated general

Procedures: N/A

Maternal Significant History, Complications, Concerns:
IUGR, Hx of PCOS, ↑HR, ↓ urine output post op

4. Lab Values-Maternal:
Blood Type and Rh: A+ **Antibody Screen:** (−)

If Rh neg, was RhoGAM given at 28-32 Weeks:

Antepartum Testing done during pregnancy:

Rubella: Immune **VDRL/RPR or Treponemal:**

HIV: (−) **Gonorrhea:** (−) **Chlamydia:** (−)

HBsAg: (−) **GBS:** (−) **PAP:** Normal

Glucose Screen: 108 **3 Hr. GTT:**

H&H on admission: 36.8 Hemo 13.0 Hem **PP H&H:** Ø Dr. Blann

Other Labs: Ø

5. Newborn Information:
Sex: Female

Apgar: 1min: 8 **5 min:** 9 **10 min, if needed:**

Weight: 4 lbs. 5.7 oz. or 1975 gms.

Length: 18 in. / 45.7 cms.

Admitted to NBN NSY: **NICU:**

Voided: **Stooled:** ✓ around 0715

Newborn Complications, Concerns:
Elevated temp

Method, Frequency & Type of Feeding:
Bottle neosure | 3hrs - 10mL

6. Lab Values/Procedures-Newborn:
POC Glucose: 50 **Blood Type:** Ø **Coombs:** Ø

Bilirubin: done @ 24 hours

O2 Saturation: Pre-ductal: 24 hours **Post-ductal:** done @ 24 hrs

Other Labs: Blood culture done @ 0700 CBC ordered for Midnight

Hearing Screen:
Done at Discharge

Circumcision: Female

Adopted: August 2016

Student Name: Shallas Taylor

Date: 2/7/24

7. Focused Nursing problem:

Infection prevention/ surgical site care

8. Related to (r/t):

incision from c-section

9. As evidenced by (aeb):

s/s of infection: redness, swelling, Fever, N/V, drainage around site

s/s of wound open: bleeding or visual opening.

10. Desired patient outcome:

The patient is afebrile and free of purulent drainage or redness around surgical site

The patient achives timely wound healing without complications

11. Nursing Interventions related to the Nursing Diagnosis in #7:

1. Freqnent incision site checks

Evidenced Based Practice:

This will allow us to catch infections earlier and allow tx to start sooner. Allows us to also catch poss. complications such as surgical site opening.

2. Monitor vitals

Evidenced Based Practice:

Elevated temp and HR could be early signs of infection and will allow us to tx sooner.

3. Clean surgical site/assist with

Evidenced Based Practice:

Teaching patient how to properly clean site will help prevent infections. ~~It~~ importance of hand washing to keep bacteria from our hand from getting on surgical site

4 Encourage use of using pillow to hold against incision site during cough/sneeze

Helps incision pain and provides resistence which helps comfort pt.

12. Patient Teaching:

1. Wash hands prior to touching around incision site
2. Teach patient normal healing stages and what expect vs what is not normal (redness, swelling discharge)
3. Teach patient to use pillow around incisional area when coughing, sneezing to support that area and help with pain

13. Discharge Planning/Community Resources:

1. Teach patient how to clean incision site and remind patient not to submerge (bath) until released by physican. Provide HCG soap or encourage Antibacterial.
2. Teach patient to take pain meaications are directed to prevent break through pain of incision site - Teach pt to report any redness, swelling, drainage, fever to Dr. Blann immediately.
3. Teach patient to follow up w/ dr. blann as directed so that he can assess healing Make sure follow up appt is Made.
4. Teach patients about complication of surgical site opening. if this occurs teach patient to notify Dr. Blann immediately and go back to OB ED.
5. Teach patient to avoid lifting heavy objects as wound heals