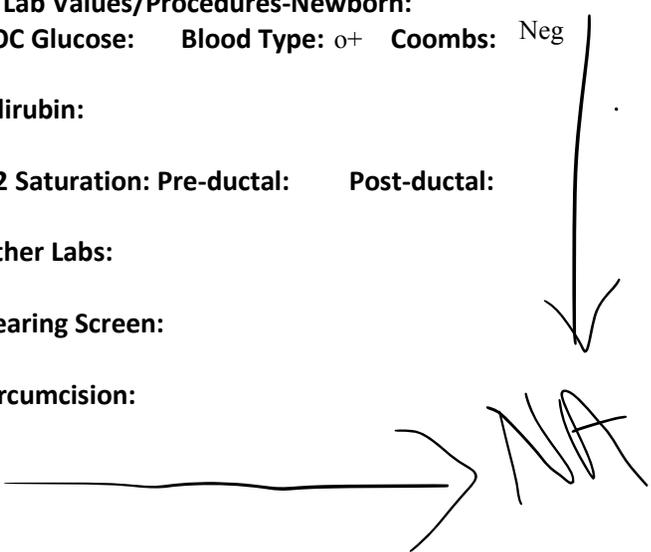


IM6 (OB) Critical Thinking Worksheet

<p>Student Name: Kristen Gustafson</p>		<p>Date: 4/30/24</p>
<p>1. Diagnosis: Post Partum Hemorrhage</p> <p>Admission Date and Time: 4/29 @0700</p> <p>Age: 30 Race: W Marital Status: married</p> <p>Allergies: NKDA</p> <p>LMP: 7/24/23</p> <p>EDD: 4/29 Prenatal Care: Henderson</p>	<p>2. Delivery Information:</p> <p>Delivery Date and Time: 4/29 @1412</p> <p>Vaginal/CS: <input checked="" type="checkbox"/> If C/S, reason:</p> <p>Incision or Lacerations: mediolateral episiotomy</p> <p>Anesthesia/Analgesia in L & D: epidural</p> <p>BTL: N/A Quantitative Blood Loss: 1088</p> <p>Gestational Age at Delivery: 40</p>	<p>3. Maternal Information:</p> <p>Foley: dc @ 1543 Voiding Past Removal: 500 ml</p> <p>IV: Left ac V/S: Q4</p> <p>Activity: ambulatory Diet: Veg</p> <p>Procedures: Forceps assisted delivery 2 pulls</p> <p>Maternal Significant History, Complications, Concerns: High Bleeding risk due to Vaginal wall laceration during labor. Hx of breast augmentation</p>
<p>4. Lab Values-Maternal:</p> <p>Blood Type and Rh: o+ Antibody Screen:</p> <p>If Rh neg, was RhoGAM given at 28-32 Weeks:</p> <p>Antepartum Testing done during pregnancy:</p> <p>Rubella:Immune VDRL/RPR or Treponemal: Neg</p> <p>HIV: Neg Gonorrhea: Neg Chlamydia: Neg</p> <p>HBsAg: Neg GBS: Neg PAP: Neg</p> <p>Glucose Screen: 3 Hr. GTT: 1 hour = 110</p> <p>H&H on admission: $\frac{10.8}{32.6}$ PP H&H: $\frac{9.6}{27.5}$</p> <p>Other Labs:</p>	<p>5. Newborn Information:</p> <p>Sex: F</p> <p>Apgar: 1min: 8 5 min: 9 10 min, if needed:</p> <p>Weight: lbs. or oz. gms. 3685</p> <p>Length: 19 in. / cms.</p> <p>Admitted to NBN NSY: <input checked="" type="checkbox"/> NICU:</p> <p>Voided: <input checked="" type="checkbox"/> Stooled: <input checked="" type="checkbox"/></p> <p>Newborn Complications, Concerns: NICU Attend delivery. Forceps assisted 2 pulls</p> <p>Method, Frequency & Type of Feeding: Breastfeeding every 2-3 hours.</p>	<p>6. Lab Values/Procedures-Newborn:</p> <p>POC Glucose: Blood Type: o+ Coombs: Neg</p> <p>Bilirubin:</p> <p>O2 Saturation: Pre-ductal: Post-ductal:</p> <p>Other Labs:</p> <p>Hearing Screen:</p> <p>Circumcision:</p> <div style="text-align: right; margin-top: 20px;">  </div>

Student Name:		Date:
7. Focused Nursing problem: Post Partum Hemorrhage	11. Nursing Interventions related to the Nursing Diagnosis in #7: 1. Quantify blood loss Evidenced Based Practice: Saturating a pad within 15 minutes signals excessive bleeding. Finding of large blood clots abnormal. 2. BUBBLE HEB assessment Q 4	12. Patient Teaching: 1. Bleeding may increase with ambulation, this is a normal finding. 2. Notify nurse/provider if bleeding is saturating a new pad within 15 minutes. 3. Use ice packs for perineal discomfort. Cool water/sitz baths may help. Sitting at a 30 degree incline will help keep pressure off the perineal area.
8. Related to (r/t): Vaginal wall laceration		
9. As evidenced by (aeb): delivery of newborn with forceps assist	Evidenced Based Practice: Assessment every 4 hours will help determine if patients condition is worsening, specifically by monitoring the fundus and helping to monitor lochia. 3. Vitals Q 4	13. Discharge Planning/Community Resources: 1. Talk to your PCP if you experience prolonged and increased sadness, or feelings of harming yourself or others arise. 2. Continue to monitor lochia to determine appropriate healing. Teaching of Rubra, Serosa, and Alba stages. 3. Safe sleep education
10. Desired patient outcome: Decreased lochia and complete healing of laceration	Evidenced Based Practice: Monitoring Vitals every 4 hours will help watch out for low blood pressure, low heart rate or low respiratory rate that can suggest hemorrhaging/excessive loss of blood	