IM6 (OB) Critical Thinking Worksheet

Student Name: Kristen Gustafson

Date: 4/30/24

1. Diagnosis: Post Partum Hemmorhage

Admission Date and Time: 4/29 @0700

Age: 30 **Race:** W **Marital Status:** married

Allergies: NKDA

LMP: 7/24/23

EDD: 4/29

Prenatal Care: Henderson

2. Delivery Information:

Delivery Date and Time: 4/29 @1412

Vaginal/CS: √ **If C/S, reason:**

Incision or Lacerations: mediolateral epesiotomy

Anesthesia/Analgesia in L & D: epidural

BTL: N/A **Quantitative Blood Loss:** 1088

Gestational Age at Delivery: 40

3. Maternal Information:

Foley: dc @ 1543 **Voiding Past Removal:** 500 ml

IV: Left ac **V/S:** Q4

Activity: ambulatory **Diet:** Veg

Procedures: Forceps assisted delivery 2 pulls

Maternal Significant History, Complications, Concerns:
High Bleeding risk due to Vaginal wall laceration during labor. Hx of breast augmentation

4. Lab Values-Maternal:
Blood Type and Rh: o+ **Antibody Screen:**

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

Antepartum Testing done during pregnancy:

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

HIV: Neg **Gonorrhea:** Neg **Chlamydia:** Neg

HBsAg: Neg **GBS:** Neg **PAP:** Neg

Glucose Screen: 1 hour = 110 **3 Hr. GTT:**

H&H on admission: 10.8 / 32.6 **PP H&H:** 9.6 / 27.5

Other Labs:

5. Newborn Information:
Sex: F

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

Weight: ~~lbs. oz. or~~ gms. 3685

Length: 19 in. / cms.

Admitted to NBN NSY: √ **NICU:**

Voided: √ **Stooled:** √

Newborn Complications, Concerns:
NICU Attend delivery.
Forceps assisted 2 pulls

Method, Frequency & Type of Feeding:
Breastfeeding every 2-3 hours.

6. Lab Values/Procedures-Newborn:
POC Glucose: **Blood Type:** o+ **Coombs:** Neg

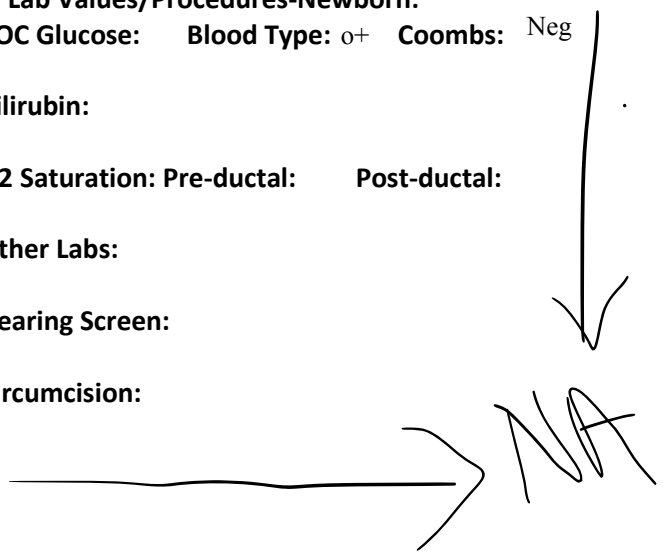
Bilirubin:

O2 Saturation: Pre-ductal: **Post-ductal:**

Other Labs:

Hearing Screen:

Circumcision:



Student Name:		**Date:**
7. Focused Nursing problem: Post Partum Hemmorhage	**11. Nursing Interventions related to the Nursing Diagnosis in #7:** **1.** Quantify blood loss **Evidenced Based Practice:** Loss of more than 1000 ml of blood during delivery. Saturating a pad within 15 minutes signals excessive bleeding. Finding of large blood clots abnormal. **2.** BUBBLE HEB assessment Q 4 **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 **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 hemmorhaging/excessive loss of blood	**12. Patient Teaching:** **1.** Bleeding may increase with ambulation, this is a normal finding. **2.** Notify nurse/provider if bleeding is saturing 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 from delivery of newborn with forceps assist.		
9. As evidenced by (aeb): delivery of newborn with forceps assist		**13. Discharge Planning/Community Resources:** **1.** Talk to your PCP if you experience prolongued 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: Light to scant lochia turning to pink/ brown by day 4. Scant to none by day 10.		