Name: Williams, Cynthia	Room 1
DOB: 05/06/XXXX	31 y/o F
MR # 547683190	
Dr. Baby Delivery	

Situation

Chief Complaint / Diagnosis: Pregnancy at 38 3/7 weeks, history of Gestational Diabetes, elevated B/P.

Allergy: Morphine **Code status**: Full

Background

Pertinent Medical History: 31 y/o G3 P2, L 1, EDC 08/10/XX,
History of pre-eclampsia 1st pregnancy, the infant weighed 10 lbs., 8 oz. Second pregnancy stillborn at 39 weeks. Prenatal care began at 8 weeks with the diagnosed of gestational diabetes which has been controlled with insulin. The patient has been on bedrest for the past 3 weeks due to elevated B/P. Last prenatal visit B/P was 146/94, cervical exam 3cm / 90% / Cephalic / O station

Home Medications: Prenatal Vitamins, Insulin

Pertinent *RECENT* History: Patient reports she has been contracting most of the night and had SROM @ 0130

Assessment

Current Vital Signs: T 98.6, HR 84, R 18, B/P 136/84, O2Sat 98% on RA, and FHR 150 with moderate variability, accelerations present.

Vaginal Exam: 5-6 cm / 90% / -1; Nitrazine positive; leaking clear fluid.

Safety Concerns: Risk for falls due to pregnancy.

Pertinent Assessment: 18 gauge IV to the left arm, LR infusing at 125 ml/hr. Oxytocin 30unit to 500 ml LR infusing at 6 mu/min (6ml/hr.). Contractions q 2-3 min., lasting 70-80 sec. The patient is tolerating labor at this time.

Recommendation

Enter room; prioritize care according to subjective and objective data

- Implement and maintain universal competencies.
- Perform obstetrical nursing assessments.
- Prioritize and implement nursing interventions.
- Provide patient teaching related to assessments and interventions.

Pertinent Lab / Dx test results: Prenatal labs and Assessment Center's admission labs drawn 05/05/XX at 1530

Lab	Patient	Ref. Range
HIV	Negative	Negative
RPR/VDRL	Negative	Negative
HbsAG	Negative	Negative
Rubella	Immune	Immune
GBS	Negative	Negative
Blood Type & Rh	O Negative	
CBC		
WBC	18.5 **H**	4.8 - 10.8
RBC	4.6	4.2 - 5.4
Hgb	12.5	12.0 - 16.0
Hct	38.4	37 - 47
Platelets	270	150 - 400
MCV	81	81 - 99
MCH	29	27 - 34
MCHC	34	33 - 36
RDW	12	11.5 - 14.5
MPV	7.6	7.4 - 10.4
CMP		
K	3.8	3.5 - 5.2 meq/L
NA	139	136 - 145 meq/L
Cl	102	96 - 106 meq/L
Ca	9.2	8.4 - 10.7 mg/dl
CO2	27	23 - 30 meq/L
Creatine	0.7	0.5 - 1.0 mg/dl
BUN	7	6 - 20 mg/dl
Glucose	148 **H**	80 - 110 mg/dl
Albumin	3.8	3.5 - 4.8 g/dl
Total Protein	6.7	6.3 - 8.6 g/dl
Alkaline Phosphatase	28	25 - 100 U/L
ALT	36 **H**	7 - 35 U/L
AST	38 **H**	10 - 36 U/L
Total Bilirubin	0.5	0.3 - 1.0 mg/dl

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Orders

Allergies: Morphine

1. **Diagnosis**: 38 3/7 wks., history of Gestational Diabetes, elevated B/P, admit for induction of labor
2. Perform Leopolds's; Fetal Monitoring upon admission
3. IV LR 1000 ml to infuse at 125 ml/hr. with 18 g cath.
4. LOW DOSE PROTOCOL: Oxytocin 30 units / 500 ml IV piggyback to mainline via infusion pump.
   Start Oxytocin at 1-2 milliunits/min. (1-2 ml/hr.) Increase by 1-2 milliunits/min (1-2 ml/hr.)
   Titrate to achieve 7 contractions in 15 minutes Do not exceed a maximum of 20 milliunits/min.
5. For Non-Reassuring Fetal Heart Rate Patterns:
   Change the maternal position.
   Administer a 500 ml LR bolus.
   Decrease or discontinue oxytocin.
   Oxygen @ 10L/min via non-rebreathing mask.
   Terbutaline 0.25 mg (0.25 ml) SQ for Tachysystole or non-reassuring Fetal Heart Rate.
   Notify the physician of FHR pattern, interventions, and response.
6. Meperidine 25 mg IVP prn every 2 hrs. moderate to severe pain (4/10).
7. Promethazine 12.5 mg IVP every 4 hrs. prn (diluted in 10 ml. Saline) for nausea.
8. Blood Glucose: AC / Bedtime, and PRN
9. HumaLog insulin SQ

Blood Sugar	**Insulin Coverage**
Less than 50	Less than 50 Give 1 amp D50 and call physician
Less than 70	Less than 70 Use hypoglycemia protocol below
70-149	No coverage
150-200	2 Units
201-250	4 Units
251-300	6 Units
301-350	8 Units
351-450	10 Units and Notify physician
Greater than 450	10 Units order STAT glucose in lab, and Notify physician

Physician Signature: *Baby Delivery, MD* **Date &Time: Today @ 0600**