Connecticut Valley Hospital Nursing Policy and Procedure	**SECTION B: THE NURSING PROCESS CHAPTER 6: ADMISSION, NURSING ASSESSMENT, NURSING REASSESSMENT** **POLICY AND PROCEDURE 6.6: CARE OF PREGNANT PATIENTS**
Authorization: Nursing Executive Committee	Date Effective: May 1, 2018 Scope: Connecticut Valley Hospital

Standard of Practice:
The registered nurse will perform the clinical assessment of each pregnant patient taking into consideration the physician orders and patient condition.

Standard of Care:
Each pregnant patient can expect a professional assessment by a Registered Nurse under the direction of a physician.

Policy:
All pregnant patients of Connecticut Valley Hospital will be offered and encouraged to participate in prenatal care, with on-going obstetrical consultation. This is in addition to psychiatric, substance abuse treatment and general medical care.

- *BACKGROUND CONSIDERATIONS: Leading causes of maternal death are hemorrhage, hypertensive disorder, pulmonary embolism, amniotic fluid embolism, infection and pre-existing chronic medical conditions. The risk of maternal death had been found to be increased with the following: African American women; Pre-pregnancy obesity, Concomitant medical problems, especially hypertension, DVT, history of pulmonary embolism or other embolic events, bleeding disorder, diabetes, and lack of prenatal care.*

Procedure:
The nursing process will be used to identify the problem/s, goal/s and intervention/s to provide prenatal care. The nursing care is performed by the RN and includes, but is not limited to observation, monitoring, assessment, evaluation and documentation of the following during pregnancy:

- Pain
- Abdominal or pelvic discomfort
- Cramping

- Discharge
- Vaginal bleeding or spotting
- Nausea and/or vomiting
- Constipation
- Leg Cramps
- Edema of the legs or other parts of the body
- Heart burn
- Urinary frequency
- Hemorrhoids
- Vital Signs (blood pressure, heart rate, temperature, and respirations)
- Nutritional status
- Weight
- Fetal Movement Monitoring: accomplished by asking the patient about her feeling fetal movements every shift, starting at week 18 of gestation (or as directed by a physician's order)

Any abnormal findings will be reported to the physician and documented in the Integrated Progress Note section of the chart by the RN.

POST PARTUM GUIDELINES:

The nursing process will be used to identify the problem/s, goal/s and intervention/s to provide post partum care. The nursing care is performed by the RN and includes, but is not limited to, observation, monitoring, assessment, evaluation and documentation of the following for 45 days after delivery:

- Vaginal bleeding/discharge – pad counts with monitoring of the character, quantity, color, etc.
- Episiotomy pain – also provide education regarding hygiene to keep perinea clean
- Pain, redness, drainage or opening of the Cesarean section suture line
- Cramping
- Breast discomfort/engorgement or discharge
- Fever
- UTI
- Headache
- Bowel movements
- On-set of menses (expected in 6 – 8 weeks following delivery)
- Symptoms of depression or psychosis

Nursing interventions include scheduling OBGYN appointments and dietary consult as prescribed by the physician. The RN will notify the Infection Control Practitioner of the need for an ICP consult and education. The interventions will include ongoing support to enhance recovery and discharge planning.