

Cesarean Section Care Map

Preparation for Transfer of Care to the Community Discharge when all outcomes are met	Initial	
1. Collect live birth registration form		
2. Record of Postpartum Learning completed		
3. Newborn Metabolic Screening Completed	to be completed	
4. Newborn Hearing Screening Completed	to be completed	
5. Transcutaneous Bilirubin completed		
6. Discussed Public Health Nurse referral and contact	 YesNo	
 Verify address and phone # for 		
immediate postpartum period on		
Postpartum Referral Form		
Verify permanent address and phone # on		
Postpartum Referral Form 7. Complete the Post Partum Referral form and fax to the		
Include:	e Public Health Office.	
Breastfeeding Plan	□ N/A	
Social Work Summary	$\square N/A$	
8. Patient Aware of Postpartum Follow-Up appointments		
9. Discharge prescription given	Yes No N/A	
10. Winrho administered	Yes No N/A	
11.MMR vaccine administered	Yes No N/A	
12.BCG vaccine administered	Yes No N/A	
N/A		
13. Hepatitis B vaccine administered	Yes No N/A	
14. Teaching Package provided	Yes No* (IPN)	
15. Discharged at hours of	D/M/Y	
With Newborn Without Newborn	orn	
If discharged home without newborn, explain		

					Vital Signs & Assessments: On admission to the ward, q1h x 2, q4h until 24 hours, q8h 24- 48 hours,											
Delivery Date: TIME:					then BID until discharge and PRN											
	Vital Sign							S								
D/M/Y																
Time																
Temp																
Pulse																
Resp																
BP																
O2 Sat																
Initial																

				0 – 24 HOURS						25- 48 HRS		
	Assessment Outcomes Date: Time:											
	Consult Social work as necessary											
	Other Consults Breasts: soft, nipples comfortable to slightly tender											
Α	Breasts: soit, hipples confionable to slightly tender											
S S	soft to filling, nipples comfortable to slightly tender											
E S	Fundus: firm, midline at level of umbilicus or slightly below											
S M	firm, midline at U1 - U2 or lower											
Е	Lochia: small to moderate rubra, small clots											
N T	small to moderate rubra or serosa, small clots											
S/ C	Bladder: bladder not palpable, foley draining clear/amber urine											
O N	bladder feels empty following voids, no pain on urination											
S U	Bowels: bowel sounds present, passing flatus, no bowel movement expected											
L T	Lower Extremities: less than +2 edema, no calf tenderness on ambulation											
S	Perineum: healing, minimal swelling/bruising, no signs of infection or hematoma, wound edges well approximated											
	Chest: no pain on inspiration, no shortness of breath and chest clear											
	Dressing: dry and intact											
	IV site: healthy and patent											
	Pain: States comfortable, or controlled with analgesia											
	TESTS D/M/Y/TIME			TES						M/Y/	ГІМЕ	
1			4	 								
2		:	5	 								
3			6									

Care	Vital Signs & Assessments: On admission to the ward, q1h x 2, q4h until 24 hours, q8h 24- 48 hours, then BID until discharge and PRN														
		0 – 24 HOURS									25-48 HOURS				
	Date: Time:														
TESTS	Other:														
	Intake and output until IV and foley discontinued and voiding adequately														
TREATMENT	 Discontinue foley 12 – 24 hours if urine output greater than 30 mL/hour: D/C'd at														
TREA	 TED Stockings until mobilizing 														
	Other: Incision (if open to air): clean, well proximated no														
	redness or exudate Intravenous:														
TION	 Discontinue IV when patient drinking well, voiding adequatley and afebrile 														
MEDICATION	IV discontinued at with cathlon intact Date/Time Initial														
	Other:														
UTRITI ON	Clear fluids increase as tolerated														
NN	Tolerates diet														
	Call bell/forms explained														
ИТΥ	Encourage activity/ambulation														
CTIV	Shower														
SAFETY/ACTIVITY	Encourage deep breathing and coughing and range of motion q1h while awake														
SAF	Other:														
	Tolerates Mobilization														
	Assess emotional status, energy level														
ч	Assess parental-infant interaction														
PSYCHO- SOCIAL	Positive affect														
PS S(Cares for own physical needs or requires minimal assistance														
	Demonstrates positive parent-infant interaction														

Care	Мар	continued-	49 –	96	HOURS
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Vital Signs & Assessments BID

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			ſ	I	Vital Signs	1 1								
	D/M/Y													
	Time													
	Temp													
	Pulse													
	Respira	ations												
	BP													
	O2 Sat.													
	Initial													
	Asses	sment Ou	itcomes			Date:								
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			-	fortable to slightly ter	nder									
es	TS		s: firm, midline at U/											
Not	INSI		small to moderate											
SSS	CON		r: bladder feels emp											
Progress Notes	NTS	Bowels	: passing flatus, no											
Pr	SME	Lower	Extremities: less the											
Integrated	ASSESSMENTS/CONSULTS		um: healing, minima well approximated											
egr	AS		Chest: no pain on inspiration, no short of breath and chest clear											
=		Incisio	n: clean, well approx											
*		States	comfortable or pain											
	TS/ AT- ITS	TED St	ockings until mobilizin	g										
	TESTS/ TREAT- MENTS	Other:												
	γ's													
	MEDICA- TIONS	 Intraver IV disco 	nous: ontinued at	_ with cathlon intact										
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	NUTRI -TION	Tolerat												
	۶Ł	• Encour	age activity/ambulatio											
	SAFETY/ ACTIVITY	Shower												
-	o ₹	Fully m												
			emotional status, ene											
	ΑĠ		parent-infant interacti	on					_					
	PSYCHO- SOCIAL		e affect											
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		Demon	strates positive pare	ent-infant interaction										