



**Caesarean Section Perinatal
Loss Care Map**

Preparation for Transfer of Care to the Community Discharge when all outcomes are met	Initial
1. Stillbirth Registration Form completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
2. Birth Registration Form completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
3. Death Registration Form completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
4. Loss of Your Baby Release Form - Bilingual completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
5. Stillborn Assessment Form completed <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
6. Shared Health Necropsy Clinical Data <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
7. Consent for Autopsy - Bilingual <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
8. Pathology Services Requisition <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
9. Request for Placenta Examination <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
10. Notification of Death <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
11. Record of Postpartum Learning completed <input type="checkbox"/> Yes	
12. Discussed Public Health Postpartum Referral and contact <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Verify address and phone # for immediate postpartum period on Postpartum Referral Form <input type="checkbox"/> Yes <input type="checkbox"/> No	
• Verify permanent address and phone # on Postpartum Referral Form <input type="checkbox"/> Yes <input type="checkbox"/> No	
13. Complete the Post Partum Referral form and fax to the Public Health Office. Include:	
• Social Work Summary <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
• Ensured PH is aware of the stillbirth/neonatal death <input type="checkbox"/> Yes <input type="checkbox"/> No	
14. Patient aware of Postpartum Follow-Up appointment <input type="checkbox"/> Yes <input type="checkbox"/> No	
15. Discharge prescription given <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
16. WinRho administered <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
17. MMR vaccine administered <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A	
18. Bereavement Package and keepsakes given <input type="checkbox"/> Yes <input type="checkbox"/> No* (IPN)	
19. STBBI investigation completed <input type="checkbox"/> Yes <input type="checkbox"/> No* (IPN)	
20. Discharged at _____ hours of _____ D/M/Y	

Care Map – FIRST 48 HOURS

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

Delivery Date: _____ TIME: _____

Vital Signs											
D/M/Y											
Time											
Temp											
Pulse											
Resp											
BP											
O2 Sat											
Initial											

ASSESSMENTS/CONSULTS	Assessment Outcomes	Date: Time:	0 – 24 HOURS						25- 48 HRS		
	Consult										
	• Social work as necessary										
	<input type="checkbox"/> Other Consults _____										
	• Breasts: soft										
	soft to filling										
	• Fundus: firm, midline at level of umbilicus or slightly below										
	firm, midline at U1 - U2 or lower										
	• Lochia: small to moderate rubra, small clots										
	small to moderate rubra or serosa, small clots										
	• Bladder: bladder not palpable, foley draining clear/amber urine										
	bladder feels empty following voids, no pain on urination										
	• Bowels: bowel sounds present, passing flatus, no bowel movement expected										
	• Lower Extremities: less than +2 edema, no calf tenderness on ambulation										
	• 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										
	• Intravenous site: healthy and patent										
	• Pain: States comfortable, or controlled with analgesia										

* = Integrated Progress Note (IPN)

TESTS	D/M/Y/TIME	TESTS	D/M/Y/TIME
1. _____		4. _____	
2. _____		5. _____	
3. _____		6. _____	

Care Map continued– FIRST 48 HOURS

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:													
TEST S	<input type="checkbox"/> Other _____												
	<ul style="list-style-type: none"> Intake and output until intravenous and foley discontinued and voiding adequately <input checked="" type="checkbox"/> Discontinue foley 12 – 24 hours if urine output greater than 30 mL/hour: discontinued at _____ Date/Time _____ Initial _____ Due to void _____ Date/Time _____ Initial _____ <input checked="" type="checkbox"/> Dressing: if dry and intact leave on until discharge; change if needed and notify physician if concerns <input type="checkbox"/> TED Stockings until mobilizing <input type="checkbox"/> Other: _____ Incision (if open to air): clean, well proximated no redness or exudate 												
MEDICATION	<input type="checkbox"/> Intravenous: _____												
	<input checked="" type="checkbox"/> Discontinue intravenous when patient drinking well, voiding adequately and afebrile												
	<ul style="list-style-type: none"> Intravenous discontinued at _____ with cathlon intact _____ Date/Time _____ Initial _____ <input type="checkbox"/> Other: _____ 												
NUTRITION	<input checked="" type="checkbox"/> Clear fluids increase as tolerated												
	<input checked="" type="checkbox"/> Tolerates diet												
SAFETY/ACTIVITY	<input checked="" type="checkbox"/> Call bell/forms explained												
	<input checked="" type="checkbox"/> Encourage activity/ambulation												
	<input checked="" type="checkbox"/> Shower												
	<input checked="" type="checkbox"/> Encourage deep breathing and coughing and range of motion q1h while awake												
	<input type="checkbox"/> Other: _____												
	<input checked="" type="checkbox"/> Tolerates Mobilization												
PSYCHO-SOCIAL	<input checked="" type="checkbox"/> Assess emotional status, energy level												
	<input checked="" type="checkbox"/> Grieving process/emotional status appropriate												
	<input checked="" type="checkbox"/> Cares for own physical needs or requires minimal assistance												

Delivery Date: _____ Time: _____

Vital Signs						
D/M/Y						
Time						
Temp						
Pulse						
Respirations						
BP						
O ₂ Sat.						
Initial						

Date:

Assessment Outcomes

Time:

ASSESSMENTS/CONSULTS	<input type="checkbox"/> Consults _____													
	• Vital signs within normal range													
	• Breasts: soft to filling comfortable to slightly tender													
	• Fundus: firm, midline at U/1 – U/2 or lower													
	• Lochia: small to moderate rubra or serosa, small clots													
	• Bladder: bladder feels empty following voids, no pain on urination													
	• Bowels: passing flatus, no bowel movement expected													
	• Lower extremities: less than +2 edema, no calf tenderness on ambulation													
	• Perineum: healing, minimal swelling/bruising, no signs of infection of hematoma, wound edges well approximated													
	• Chest: no pain on inspiration, no short of breath and chest clear													
	• Incision: clean, well approximated, no redness or exudate													
	• States comfortable or pain controlled with analgesia													
TESTS/TREATMENTS	<input type="checkbox"/> TED stockings until mobilizing													
	<input type="checkbox"/> Other: _____													
MEDICATIONS	<input type="checkbox"/> Intravenous: _____													
	• Intravenous discontinued at _____ with cathlon intact _____ Date/Time _____ Initial _____													
NUTRITION	<input checked="" type="checkbox"/> Clear fluids increase as tolerated													
	• Tolerates diet													
SAFETY/ACTIVITY	• Encourage activity/ambulation													
	• Shower													
	• Fully mobile													
PSYCHO-SOCIAL	• Assess emotional status, energy level													
	• Grieving process/emotional status appropriate													
	• Cares for own physical needs or requires minimal assistance													

* = Integrated Progress Notes