Hypertensive/ Pre-eclampsia Care Map

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Vital Signs						
Date	**Time**	**Blood Pressure**	**Pulse**	**Respiration/ O_2 saturation**	**Temperature**	**Initials**

Steriods given if under 34 weeks GA:

_____ mg _____ Date: _____ Time: _____ Initials _____
_____ mg _____ Date: _____ Time: _____ Initials _____

SKU# 03526 February 2017

OBSTETRICAL ASSESSMENTS											
	D/M/Y										
	Time										
Contractions	Mode (T,IUPC,P)										
	Frequency (min)										
	Duration (sec)										
	Intensity (W, M,S)										
	Resting tone (S,F)										
FHR - Auscultation	FHR (bpm)										
	Rhythm (R, I)										
	Accelerations (Ø, √)										
	Decelerations (Ø, √)										
	Classification (Normal, Abnormal)										
FHR - EFM	Mode (U/S, SE)										
	Baseline FHR (bpm)										
	Variability										
	Accelerations (Ø, √)										
	Decelerations (Ø, √)										
	Classification (Normal, Atypical, Abnormal)										
Initial											

Vaginal Exams								
Date	Time	Presentation	Dilation	Station	Effacement	Membranes	PV discharge	Initials

Record of Patient Learning			
	Review Date	*See IPN	Nurse's initials
Call bell system			
Central Nervous system			
Respiratory			
Cardiovascular			
Gastrointestinal			
Genito-urinary			
Skin/hygiene			
Activity			
Psychosocial			
Intravenous			
Misc			

ASSESSMENTS											
	Date:										
	Time:										
Consult	• Social work as necessary										
	☐ Other										
Central Nervous System	• Level of consciousness										
	• Deep tendon reflex - Right										
	• Deep tendon reflex - Left										
	• Negative for clonus - right										
	• Negative for clonus - left										
	• No headache										
	• No altered vision										
	• No weakness/dizziness										
	• No facial edema										
	• No seizure activity										
Respiratory/ Cardiovascular	• Chest Sounds - Right										
	• Chest sounds - Left										
	• Respiratory rate – 12-22/min, normal										
	• DB&C encouraged										
	• No edema										
	• HR Regular										
Gastro-intestinal	• Diet _____										
	• Amount eaten										
	• No Nausea/vomitting										
	• No Epigastric or right upper quadrant pain										
Genito-urinary	• Voiding without difficulty										
	• Urine appearance										
	• Nitrates										
	• Sugar										
	• Ketones										
	• Urine output adequate										
	• 24 hr urine being collected										
Hygeine	• Shower/sponge/shampoo										
	• Skincare										
	• Peri/Foley care										
Activity/Safety	• Type of activity										
	• Frequency										
	• Steady gait when walking										
	• Side rails up & padded										
	• Sleep – Well/Intervals/Awake										
Psycho-social	• Emotional status										
	• Visitors – Family/friends										
	• Minimal stimulation										
Intravenous	• Normal – No signs of infection/infiltration										
	• Solution Rate _____										
	• Maintaining fluid restriction of _____mLs/hr										
	• Site/IV tubing change										
	*** Initiated on Magnesium Sulfate Care Map***										
	Initial										

Investigations

Maternal Bloodwork							Date		
Date							INR		
Hgb							Ca		
WBC							Mg		
PLT							Uric Acid		
Na							Other:		
K							**Spot Urine**		
Chloride (CLR)							UA Protein/Creatinine Ratio		
Urea (BUN)							UA Protein		
Creatinine							**Urine Values (24 hour)**		
ALT							Total Protein		
AST							Creatinine		
LDH							Creatinine Clearance		
Alk Phos (ALP)									
GGT							**Ultrasound**	**Date**	**Score**
Bilirubin – total/direct							Biophysical Profile		
Albumin									

Abbreviation Key

Contractions

Mode: T – Toco IUPC – Intrauterine pressure catheter P – Palpation
Strength: W – Weak M – Moderate S – Strong
Resting Tone: S – Soft F - Firm

FHR

Auscultation
Rhythm: R – Regular I - Irregular
N – Normal – Rate 110 – 160, Regular rhythm, No decelerations
A – Abnormal – Rate under 110, over 160, irregular or decelerations
EFM
Mode: - U/S – External monitor SE – Spiral Electrode (internal monitor)
Classification – N – Normal Aty – Atypical Abn - Abnormal

LOC

1 – Alert/Orientated
2 – Occasionally drowsy (poor concentration)
3 – Very drowsy (difficult to arouse, disorientated)
4 – Stupor (responds only to pain)

Deep Tendon Reflexes

Ø – No reflexes (notify PCP)
1+ - Decreased/present with hammer
2+ - Normal/present with hand
3+ - Brisk with hand
4+ - Hyperactive with clonus (notify PCP)

Emotional Status

C – Coping S – Coping with support A – Anxious
T – Tearful FR – Frustrated WD - Withdrawn

Seizure Activity

T – Tonic (tenseness) CL – Clonic (tense & relax)
FT - Facial twitching F – Focal (localized)
U – Unilateral (one sided)
B – Bilateral (generalized seizure)

Chest Sounds

Cl – Clear Cr – Crackles
Wh – Wheezes ↓ decreased R - Rhonchi

Urine Appearance

C – Clear Cl – Cloudy B – Blood tinged

Edema

+1 – 2mm (minimal, lower extremities)
+2 - 4mm (marked, lower extremities)
+3 - lower extremities, face & hands
+4 - generalized massive, including abdomen & face

Type Of Activity

W – Walking UR – Up in room
BR – Bedrest S – Sleep
BRP – Bedrest with bathroom privledges

Altered Vision

Dip – Diplopia Bl – Blurred Sp - Spots