PROTOCOL FOR: **Admission to the Labor & Delivery (L&D) Unit**

POLICY: Refer to Structure Standards – Labor & Delivery Unit for admission criteria.

DESIRED PATIENT OUTCOMES:

1. The patient will be oriented to the unit and hospital experience.
2. The patient and fetus' safety will be maintained throughout their stay in L&D.

CLINICAL ASSESSMENT AND CARE:

1. Assess the patient's understanding of admission/transfer.
2. Assess patient's ability to understand and carry out admission/transfer instructions (i.e., language barriers, knowledge/sensory deficits and physical limitations).
3. Patient will be placed on the external fetal monitor (EFM) at the time of admission. Refer to Unit Practice Manual for application of EFM and protocol for fetal monitoring.
4. An initial maternal-fetal assessment will be performed on each patient at the time of admission. Assessments include maternal BP, P, R, T, pain and fetal heart rate and uterine activity. Using the L&D/OB-GYN database, conduct a patient interview, history taking and assessment. Examine the fetal monitor tracing for assessment of fetal and uterine activity.
5. Begin the appropriate standard nursing care plan or carepath.
6. Establish IV access upon admission unless otherwise ordered by the physician.
7. Obtain necessary specimens as ordered by the physician for admission lab work.
8. Notify the physician of patient signs/symptoms that require immediate attention.

PATIENT TEACHING:

1. Upon admission, all patients will be given a verbal or written orientation to L&D. Explanation of visiting hours, infant security system, use of the phone, bed and call bells and specific policies will be provided as necessary. Patients will be referred to the Patient Privacy Practices in each admission folder.
2. Patient will be informed of the anticipated plan of care during her stay in L&D, including:

   a. The team of physicians who will be evaluating the patient;

   b. The various testing procedures that will be performed;

   c. The pain management plan;

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d. The importance of communication of needs between patient/family and staff; and

e. Unit guidelines for overnight visitor.

3. Give patient the hospital admission information folder, including Advance Directive and HIPPA package.

DOCUMENTATION:

1. The nursing database must be completed within 24 hours after admission. All patients must have a written plan of care within 24 hours after RN assessment and nursing diagnosis have been formulated.

2. Enter all patients onto the OB Tracevue computer system. All information entered will be stored and retained as permanent record.

3. Enter patient in the L&D admission logbook, classification sheet and unit charge sheet.

APPROVAL: Nursing Standards Committee

EFFECTIVE DATE: 12/89

REVISION DATES: 3/93, 3/97, 2/00, 8/03, 1/09, 5/09