

Guidelines

L&D/OB-GYN - Unit Practice Manual
John Dempsey Hospital-Department of Nursing
The University of Connecticut Health Center

GUIDELINES FOR: Flowsheet, Special Needs: Completion and Use of the

INTRODUCTION: The Special Needs Flowsheet is a permanent part of the patient's medical record. The nursing actions listed below should be followed to ensure correct documentation.

PROCEDURE:

<u>ACTION</u>	<u>POINTS OF EMPHASIS</u>
1. Stamp the flowsheet with the patient's identification in the appropriate space.	
2. Date the flowsheet in the appropriate space provided.	2. A new flowsheet must be started at 12:00 a.m. of each new day.
3. Place the time of entry in the far left column.	3. Time entries should be by the hour only. There are enough spaces provided for one 24 hour period.
4. Enter temperature, pulse and respirations in appropriate columns.	
5. Blood pressure: There are columns available to enter BPs taken every 15 minutes.	5. BPs taken more frequently should be entered either in the comments section or in the patient's progress notes.
6. Position: Note the patient's position using the key located in the upper right corner of the second page.	
7. DTR: Note the patient's deep tendon reflexes in this column; enter as 0, 1+, 2+, etc.	
8. O ₂ Sat: Enter the patient's O ₂ saturation, if appropriate.	

Guidelines

L&D/OB-GYN - Unit Practice Manual
 John Dempsey Hospital-Department of Nursing
 The University of Connecticut Health Center

GUIDELINES FOR: Flowsheet, Special Needs: Completion and Use of the

ACTION

POINTS OF EMPHASIS

- 9. Postpartum Assessment:
 - a. Fundus: Note whether firm or boggy and position.
 - b. Lochia: Note amount and type.
 - c. Epis: Note condition of episiotomy if applicable.
 - d. Abd Dsg: Enter condition of abdominal dressing if applicable.
 - e. Abd Inc: Note condition of abdominal incision if applicable.

9. Example:

POSTPARTUM ASSESSMENT				
FUNDUS	LOCHIA	EPIS	ABD DSG	ABD INC
FF@U	Mod Rubra	N/A	Dry & Intact	Clean & Dry
FF@U	Scant Rubra	Slightly Swollen	N/A	N/A

- 10. Medications: Enter drug, dose, route and time.

- 10. Medications must also be documented on the MAR, and Infusion Record if appropriate.

Page 2:

- 11. Comments: Enter any additional comments needed here.
- 12. Nurse Initials: Enter initials of RN making entry.
- 13. Type and Screen: Enter date of last type and screen, check off that the patient's Ident-A-Blood band is on, and note the patient's blood type.
- 14. Allergies: List all patient allergies and check off that the patient's allergy band is on.
- 15. IV Site Care: Complete as indicated, noting dates of insertion, tubing change, and dressing change. Space is provided for two IV sites.
- 16. Complete delivery information and type of anesthesia given for the delivery.

- 13. If the patient's Ident-A-Blood band is not on, note where it is located, i.e., on patient's chart.
- 14. If the allergy band is not on, note where it is located.

Guidelines

L&D/OB-GYN - Unit Practice Manual
John Dempsey Hospital-Department of Nursing
The University of Connecticut Health Center

Page 3 of 3

GUIDELINES FOR: Flowsheet, Special Needs: Completion and Use of the

ACTION

POINTS OF EMPHASIS

17. Protocols: Initial appropriate protocols for each shift. Space is provided for any additional protocols needed.
18. Safety: Check off appropriate safety measures taken for each shift.
19. All RNs caring for the patient must provide initials and signature in the appropriate boxes on the right-hand page.

CREDENTIALS: RN

REFERENCES: L&D Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 6/92

REVIEWED DATES: 9/08