

Guidelines

L&D - Unit Practice Manual

John Dempsey Hospital-Department of Nursing
The University of Connecticut Health Center

GUIDELINES FOR: Flowsheet: Completion and Use of

INTRODUCTION: The L&D flowsheet is a permanent part of the patient's record. The nursing actions stated below should be followed to ensure correct documentation.

PROCEDURE:

ACTION

POINTS OF EMPHASIS

1. Stamp the flowsheet with the patient's identification in the appropriate areas.
2. Complete the sections of the flowsheet in the following order: protocols, etc., page first, followed by flowsheet section immediately underneath, then flip flowsheet to the other side and continue with top section containing UConn logo and finish with bottom section.
3. Date flowsheet in appropriate spaces:
 - a. on protocol page.
 - b. above the word time in time box on first flowsheet section, and on each section on second side of flowsheet.
4. Protocols: RN initials must be placed in corresponding D/E/N shift boxes next to appropriate protocols for each patient.
5. Patient: fill in EDC, AOG and G/P for each patient underneath date.
6. Nurse: All RNs caring for the patient must initial and sign in appropriate boxes.

1. The patient's identification must be stamped on both sides of the flowsheet.
2. It may be necessary to use more than one flowsheet per day for a patient. If this is necessary, there is no need to complete all areas of first page (protocols, etc.), just continue with other 3 sections in the order stated to the left.

b.

MATERNAL ASSESSMENT				
				BLOOD
TIME	TEMP	PULSE	RESP	PRESSURE

4. Admission protocols should be initialed once on first flowsheet used for each patient for each day.
6. If multiple flowsheets are used for one day, initials and signatures should appear on all flowsheets used.

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7. IV site(s): note site(s) of IV, date inserted, solution being used, and dates of tubing and dressing changes.
 8. Type and screen: Note date of last type and screen, the patient's blood type and check off that the Ident-A-Blood bracelet is on the patient.
 9. Allergies: document all patient allergies and check off that allergy bracelet is on patient.
 10. Safety: Check off appropriate safety measures taken for patient in appropriate boxes for each shift.
 11. Epidural checklist: If the patient has an epidural placed for labor, complete the checklist.
 - a. Position: note position patient is in for placement of the epidural.
 - b. Cardiac monitor: on/off or yes/no.
 - c. IV fluid bolus: type and amount, or none.
 - d. O₂: yes or no. If none, state reason why (none, per anesthesia resident preference). If yes, state amount and mode, i.e., 2 liters per nasal cannula.
 12. Keys listed below protocols are to be used for the remaining three sections of the flowsheet.
8. If, for some reason, the Ident-A-Blood bracelet is not on the patient, note where the bracelet is located (i.e., on chart, etc.)
 9. If bracelet is not on the patient, note where it is located.

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13. Time: note times of entries in far left column.

14. Maternal Assessment: enter patient's temperature and vital signs in appropriate columns.

15. FHR Assessment:

- a. Rate: note mode of monitoring and range of fetal heart rate.
- b. Variability: LTV and STV should be entered using appropriate keys.

15. Example:

FHR Assessment		
Rate	Variability	
	LTV	STV
E/120-130's	Av	
I/130-140's	Av	P

16. Uterine Assessment:

- a. Frequency: document mode of monitoring and frequency of contractions in minutes.
- b. Intensity: if monitored externally, note intensity of contractions, using appropriate key, as mild, moderate, or strong. If monitored internally, note intensity in mmHg.
- c. Duration: note duration of contractions in seconds.
- d. Resting tone: if monitoring internally, note resting tone in mmHg.

16. Example:

Uterine Assessment		
Frequency	Intensity	Duration/ Resting Tone
E/q2 min	Mod	30-60 sec
I/q2 min	50-60 mmHg	60-90 sec /10 mmHg

17. Membranes: Note whether membranes are intact or ruptured in I/R column. Enter color of fluid if ruptured, using key, in fluid column.

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18. Vaginal exam/sterile speculum exam: Enter results of exam in this column.
19. Reflexes/clonus: enter reflexes as 0, 1+, 2+, etc. Clonus should be entered as + or -.
20. Comments: All other comments and patient position should be entered in this column. If the patient is on Pitocin, it should be documented in this section and on the Infusion Record.

20. All medications should be documented on the MAR under comments on flowsheet. Note that the patient was medicated and her response.

CREDENTIALS: RN

REFERENCES: L&D Standards Committee
Nursing Standards Committee

EFFECTIVE DATE: 6/92

REVIEWED DATES: 9/08