Maternity CPN Materials

Once you are logged into CPN in the Postpartum View, select your patient so the name appears in the Patient Banner Bar.

Maternal Documentation – transfer from L&D through discharge

1. **SBAR Quick Key** - This tab will be utilized when calling report to a physician or between L&D and Postpartum or shift to shift. The Situation & Background sections are pulled from the maternal admission assessment: green in the history section is a negative/normal finding. Red in the history section indicates a potential health issue that may need to be addressed during the hospital stay. The Assessment section pulls the most recent data from the shift assessment and flowsheet. The Recommendation section will be updated each time you utilize this form by CLICKing the *Enter New Information* to get a clear documentation field.
   
   a. If you call a physician, enter text of who was called and what was discussed in the notable communication area and any follow-up needed in the appropriate box.

   b. For nurse to nurse report, type “Report” in the communication box. Select the nurse giving report and type in the nurse receiving report in the respective boxes. The receiving nurse’s name will flow to the chalkboard to show that person as the new caregiver.

2. **Delivery** - You can review the information about the patient’s delivery or when you receive at c-sections, you will be documenting on this tab, including all of the subcomponent buttons.
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3. **Flowsheet** - After receiving report, you need to assess your patient using the **Flowsheet** Quick key. This chart replaces the blue maternal flowsheet. CLICK on the **Flowsheet** quick key, CLICK on the pencil, select the documentation time, CLICK OK and then begin documenting.

   a. There are 2 items that must be documented on this flowsheet at the initial postpartum assessment: The first item **Stage of Pregnancy** MUST be documented on this flowsheet to tell the computer which flowsheet to place the vital signs on. The **Patient Status** item will change the color on the chalkboard.

<table>
<thead>
<tr>
<th>Delivery</th>
<th>Flowsheet</th>
<th>Shift Assess</th>
<th>Teaching</th>
<th>IDN/Consults</th>
<th>VS/Graphs</th>
<th>I&amp;O</th>
<th>SBAR</th>
<th>Discharge</th>
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<tbody>
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   b. **Flowsheet All** - This is a comprehensive flowsheet that contains all information from the other tabs on this form. If you choose, you can document on this flowsheet or if you document on the other tabs, the information will flow to this tab.

c. **Vital Signs** tab for documenting vital signs, SpO2 and oxygenation if a patient is on O2 after c-section. This tab can be used by a CNA for documentation.

d. **Pain** - This can be used for documentation of pain assessment as well as pain relief measures.

e. **Assessment** - This tab contains a “BUBBLE” assessment to assess the postpartum mother. You will use this tab for your assessments after your first assessment of the shift. This also has a section for infant bonding assessment, including a note to say that the baby is skin to skin or breastfeeding.

f. **Care** - This tab will be used for CNA documentation. This tab includes vaccine administration, hygiene, pericare and designating if a lactation consult is needed. The actual lactation consult will be charted under **Patient Progress** in the menu, then selecting **Lactation Consult**.
g. **DV/Suicide** - This tab is available for documentation in case the nurse discovers additional information about the psychosocial history and needs to adjust the admission documentation. You do not need to document on this unless the patient assessment changes.

4. **Shift Assessment** - During your initial assessment for each shift after admission (i.e. 0800 or 2000); use this tab to complete a head to toe assessment to ensure the health of the patient. This only needs to be completed once per shift, including fall risk, IV assessment and Braden Scale.
   a. CLICK on the *Shift Assess* quick key, CLICK on the pencil, select the documentation time, CLICK OK and then begin documenting.

   b. **Maternal ROS** - This tab contains an entire head to toe assessment, including the postpartum specific items currently found on the blue maternal flowsheet. Complete the items that are pertinent to your patient and skip items that you do not assess.

c. **PTL/HTN** - This is a subset of items from the previous tab that focuses on assessment of the pre-eclamptic patient or one who has been on magnesium. If you document the information on the Maternal ROS tab, it will automatically flow across to this flowsheet. This tab is helpful for easy access for these assessment items

d. **Fall risk, IV assessment, Braden Scale** - These only need to be completed once per shift or when necessary (fall risk if change in condition, IV assessment if discontinuing or changing an IV).
5. **Teaching** - This tab replaces the “maternal teaching record.” It includes the orientation to the Maternity Department room as well as all topics that need to be covered before discharge from the hospital. During the patient stay as you teach different topics, you will click this tab and document the topic you taught as well as the patient’s response (i.e. verbalized understanding, returned demonstration). Do not wait until day of discharge to complete this form – it is intended to document changes in the patient’s learning progress over time and you can indicate if follow-up teaching needs to be completed.

   a. You can review what was taught in L&D by CLICKing the *Perinatal* subcomponent button.
   
   b. By CLICKing the *Review* subcomponent button, you can review all topics with the last date/time that the topic was discussed and topics that still need to be taught.

6. **Discharge** - This tab replaces the white/yellow form that the MD signs currently on day of discharge, the appointment form (except on weekends/holidays) and the back of the maternal teaching record. The MD will provide the orders to complete the left side of the page and until the MDs are live on the system, the nurse will have to enter the MD’s written orders into CPN.

   a. This form will be the last thing documented on before discharge as the nurse will document the date/time of delivery, how and with whom the patient left the floor and if they were discharged to a private vehicle or other mode of transport.

   b. By CLICKing *Discharge Instructions*, you can personalize the patient instructions to provide education on warning signs and when a patient should seek medical care. Spanish instructions will also be accessible by go-live from the discharge summary or discharge instruction page.
7. **IDN/Consults** will contain documentation on psychosocial issues, CPS referrals and newborn placement of inmates. This will be completed charge nurses or social workers. Further education will be provided before the phasing-in of this section.

8. **VS/Graphs** - This tab will allow the nurse to review all vital signs taken, regardless of stage of pregnancy. CPN also graphs the vitals to provide a visual overview of vital sign changes over time.

9. **I&O** will remain on paper temporarily. Further education will be provided before the phasing-in of this section.
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Maternal Documentation – Where do I chart and when??

1. Receiving a delivered mother from L&D or PACU:
   a. *SBAR form* – indicate date/time of transfer, select nurse giving report from drop-down box and type in receiving nurse name.
   b. *Flowsheet* - Select POSTPARTUM stage of pregnancy in 1st item, and type of delivery for patient status.
   c. *Care plans* – to be phased in after go-live. CLICK Patient Progress in the menu bar, then CLICK Care Plans.

2. On-going care once patient is on floor:
   a. *Flowsheet* - complete the appropriate tabs every 4-8 hours for your routine assessment
   b. *Teaching* – document on the teaching quick key as you provide education and feedback to your patients.
   c. *SBAR* – if you need to give report to the MD or other caregiver. Document date/time, who you reported to, the pertinent details of the conversation and what follow-up was needed or ordered.

3. To be completed once per shift
   a. *SBAR* - indicate date/time of transfer, select nurse giving report from drop-down box and type in receiving nurse name.
   b. *Shift Assessment* – Complete this for the initial assessment at 0800 or 2000, including the *Fall Risk, IV assessment* (if applicable) and *Braden Scale*.
   c. *Care plans* – to be phased in after go-live. CLICK Patient Progress in the menu bar, then CLICK Care Plans. COPY previously written care plans to update or resolve individual care plans.

4. To be completed for discharge
   a. *Teaching* quick key – Review to see that all topics have been covered.
   b. *Discharge* – complete the summary, medication reconciliation and instructions sections. PRINT 2 copies, one for the patient and nurse to sign, and one to give to the patient.