Family Maternity Center

Effective: 10/97	Policy #: TCH-FMC-A05
Reviewed: 4/00;3/04;11/06;10/08;10/12; 1/14	Responsibility: NURSING
Dept. Director: Terra Palomarez, RN	Approved: Yvana Iovino, MD
SUBJECT: ADMISSION GUIDELINES-FAMILY MATERNITY CENTER	

The Family Maternity Center is a 12 bed obstetrical department that provides care on a 24 hour basis to families. The scope of care/service for the Family Maternity Center includes the following, but is not limited to:

1. Antepartum care including medical complications.
2. Postpartum care including pre and post-op surgical patients.
3. Neonatal care including low and high-risk infants.
4. Intrapartum care including low and high-risk patients
5. Care of women after gynecologic surgery, provided there is no open active infection.

UNIT STRUCTURE:
Personnel providing direct and indirect care in FMC include Director, staff Registered Nurses, LPN's, OB Technicians, CNA, and Unit Secretaries. Ancillary department personnel such as Respiratory Therapy, Pastoral Care, Social Services, and Pharmacists may provide care to FMC patients based on obstetrical nursing care plans.

The Family Maternity Center Director is a Registered Nurse with appropriate leadership, management, and clinical skills as outlined in the job description. The Director has the responsibility, authority, and accountability 24 hours a day for management of the Family Maternity Center.

Nursing staff are educated in techniques of obstetrical nursing and use of specialized and emergency equipment. They are evaluated on nursing competency annually.

All personnel attend mandatory in-services including but not limited to implementation of new procedures and protocols, major equipment changes and annual emergency skill review.

PHILOSOPHY AND PURPOSE:
It is the goal of the Family Maternity Center at Toppenish Community Hospital that we provide a safe and nurturing environment in which a family may unite and grow, physically, emotionally and psychologically.

The mother/babe couplets' biophysical environmental self-care, educational and discharge planning needs will be addressed with the mother and her significant other(s). Appropriate data from her significant other(s) will be included in the initial and ongoing nursing assessments.

Siblings and other significant other(s) will be encouraged to visit and become involved with the care of mother and newborn. **EXCEPT DURING RSV SEASON when access to the FMC unit may be restricted by the Pediatric Committee.**

Education will be provided during her stay to both parent and significant other(s) and needs identified will be addressed before being discharged.

LOCATION AND FACILITIES
The Family Maternity Center is located in the southwest corner of the hospital and consists of 8 LDRP's ,1 triage room , 2 postpartum rooms (2 patient beds per room), and nursery (2 radiant warmers).

LDRP's are equipped with radiant warmers and fetal monitors. Delivery carts are brought into the room for delivery.

Adequate space in each patient room, to safely accommodate potential equipment and medical/nursing staff needs.
Adequate illumination: for patient assessment, special procedures, delivery of medical/nursing care.

A clock shall be visible to patients.

Life support systems, including, but not limited to: oxygen, compressed air suction outlets and emergency electrical outlets.

A communication system that provides for routine patient care as well as notification of appropriate personnel in the case of life threatening emergencies.

NURSING STAFF REQUIREMENTS:

Obstetrical personnel are expected to meet all requirements as outlined. Information regarding these programs is available. This program will include staff orientation and educational programs such as, but not limited to:

- Nursing Philosophy
- Organization
- Specialty educational program
- Mandatory educational requirements
- Obstetrical nursing competency validation

It is the belief of Toppenish Community Hospital that every obstetrical patient has the right to expect and receive nursing care provided by qualified personnel. Personnel are expected to maintain all mandatory requirements and to participate in education on a yearly basis or as deemed necessary. It is the belief that competency levels for all personnel will be documented and at a satisfactory level upon initial hire and during employment in accordance with The Joint Commission standards. Competency levels will be demonstrated by several methods and will include clinical knowledge testing and skills verification but not limited to these methodologies. Each employee is expected to complete requirements as requested by the department director.

MANDATORY EDUCATIONAL PROGRAMS:

The purpose of mandatory educational program is to update employees on new products, skills, or services to ensure that vital information is acquired and maintained by all affected personnel, and to ensure competency levels as determined by national, professional, or regulatory bodies.

POLICY:

Mandatory Education Includes:

- Basic Cardiac Life Support - Recertification required every two years
- Neonatal Resuscitation Program - Recertification required every two years. Required for employment for all Registered Nurses and support staff assisting with labor patients.
- Fire, Safety, Disaster, Infection Control, Hazardous Waste, and Electrical Safety.

Mandatory education sessions will be posted at least 14 days in advance of program. Personnel expected to attend will be designated on the posting.

It is the responsibility of the employee to attend (signing up in advance if requested) or provide the director with the reason for nonattendance prior to the start of the program. Exceptions are leaves of absence or vacations occurring during the time of the offering.

Disciplinary measures will be taken for failure to attend as required.

If an employee is unable to attend a mandatory education program, options for obtaining the information will be explored with the Director or Clinical Manager. Options may vary depending on the nature of the program.

STAFFING PATTERNS AND GUIDELINES:

Many factors must be considered when planning staff needs. These include the facility design, patient acuity population, nursing responsibilities, nurse/patient ratio, clinical expertise and qualification of staff and professional development. Nursing judgment is important in determining the staff required. Flexible, an innovative approach as opposed to rigid mathematical formula is encouraged.

A. To provide a guide to the nurse in charge to determine appropriate staffing for the on-coming shift or as staffing needs change within the shift.
B. To define schedule base staffing levels.
C. To identify appropriate nurse/patient ratios for the care provided by the perinatal service.

D. Base-staffing is based on average census, utilization and hours per patient/day. It is the number of permanently employed, registered nurses scheduled to work each shift. All RN's in the base-staffing pool are crossed-trained in all areas of Family Maternity Care.
E. The following factors influence alterations in base-staffing and help the charge RN or House Charge determine when additional staff are to be activated and/or base-staffing nurses to be "low-censused" from duty per RN/LPN contract guidelines.

1. Patient needs must match RN qualifications. Only those having completed fetal monitoring competency validation and labor and delivery training and/or skills check list may care for patients in labor. Only nurses having completed infant resuscitation courses may care for infants at delivery or during transition.
2. Availability of support services such as secretarial support and/or social services support when patients requiring or anticipated to require those services should be identified. If available, additional nursing staffing is to be considered.
3. Certain types of procedures and circumstances represent higher risk and/or special staffing considerations.

a. Antepartum clients for test and/or care
b. Care of VBAC patient
c. Epidural anesthesia
d. Post-op epidural morphine
e. Induction
f. Fetal demise
g. Infant with IV's
h. Frequent vital signs on infants

The charge nurse should use the following AWHONN nurse/patient ratio recommendations as the acceptable standard of care. On the nurses' judgment a greater nurse/patient ratio may be provided:

Antepartum testing	1:2-3
Normal Labor/High Risk Labor	1:2/1:1
2nd stage	1:1
OB patient requiring transport	1:1
Induction	1:2
Active Induction	1:1
Coverage of anesthesia/epidural	1:1
Circulate C/S	1:1
Antepartum	1:3
Postpartum recovering (without babe)	1:1 (during PACU status)
Complicated but stable (w/o babe)	1:3
Mother/baby care	1:3 (couplets)
Newborn requiring transport	1:1 or greater
Minimum staffing	2 L&D trained RNs

OPERATING POLICIES:

Admission Guidelines:

The following criteria shall be considered as guidelines for admission:

A. Pregnancy greater than 36 weeks. Pregnancy between 34 and 36 weeks per admitting Physician and/or Pediatrician discretion and per nursing availability.
B. Pregnancy without any identified fetal malformations (e.g., gastroschisis, diaphragmatic hernia, and cardiac anomalies) which would likely complicate neonatal course.

C. Gestational hypertension/pre-eclampsia. Maternal hypertension and pre-eclampsia without prematurity.
D. Insulin dependent diabetics without prematurity at discretion of attending physician.
E. Other situations after consultation with Pediatrician and attending Physician.
F. Scheduled Caesarean section (uncomplicated pregnancy).
G. Infants in hyperbilirubinemia.
H. Failure to Thrive
I. Antepartal patients with stable or easily controlled conditions not anticipated resulting in pre-term delivery or fetal compromise.
J. Gynecology patients without infectious conditions.
K. Patient with urgent or emergent conditions where transfer is contraindicated because of immediate need for treatment such as precipitous delivery, fetal intolerance to labor, etc.

MANAGEMENT OF PREGNANT PATIENTS IN THE EMERGENCY DEPARTMENT

A. Pregnant patients less than 20 weeks gestation may be managed as gynecological patients and evaluated and managed as necessary in the Emergency Department.
B. Pregnant patients more than 20 weeks gestation who present with obstetrical complaints (i.e., vaginal bleeding, uterine contractions, signs of labor) will be sent directly to the Family Maternity Center for evaluation and management. On arrival to the Family Maternity Center the patient's attending physician or the physician on rotational call for OB will be notified.
C. Pregnant patients more than 20 weeks who are admitted for non-obstetrical emergencies may be obstetrically evaluated by the Family Maternity Center nurse in the Emergency Department at the request of the Emergency physician.
D. OB patients more than 20 weeks who are seen in the Emergency Department following a MVA, but do not require admission, should be sent to Family Maternity Center prior to discharge for evaluation of fetus and to rule out preterm labor/ abruption.
E. If a patient presents to the Emergency Department following an out-of-hospital birth, mother and well-baby should be directly admitted to the Family Maternity Center. Infants requiring transport to a Level III nursery will be stabilized in the Family Maternity Center prior to transport. The patient's pediatrician or pediatrician on rotational call will be notified.
F. The Family Maternity Center charge nurse should be notified immediately of the anticipated arrival of an obstetrical emergency patient.

TRANSFER OF FMC PATIENTS TO ANOTHER FACILITY:

- Any one in stable condition not meeting admission criteria will be transferred per policy.

FAMILY MATERNITY CENTER VISITATION POLICY:

Visiting hours will be open 8:00 AM to 8:00 PM per hospital policy and may be enforced at nurse discretion. Children are encouraged to be present under adult supervision. The mother will be allowed to control the traffic of her visitors unless the nurse perceives that her visitors are being unduly disturbing.

Mothers will be asked to be aware of family members who may have an infectious condition. The mother will be taught to assume the role of protector of her child's health while hospitalized, as she will be required to do so when returning home.

During RSV season, October to May, the Pediatric Committee will determine if additional visitation restrictions are needed in order to protect the newborn.

PATIENT CARE:

Nursing care on the FMC unit is based on patient need, policy and procedure, and AWHONN and ACOG standards.

PATIENT TEACHING IN THE FAMILY MATERNITY CENTER

Patient teaching in the Family Maternity Center will be structured to reflect the understanding of time limitations following birth and before discharge of the baby/mother couplet.

All written and video information will be presented in the mothers' primary language.

Mandatory teaching will be considered the minimum presentation and meet perinatal standards. This teaching may be used for the mother whose post-partum stay is short, or for the mother for whom the post-natal education may be considered a review. It will include:

A. Discharge teaching will include verification and documentation that the mother understands.

- Cord Care
- Circumcision care
- Feeding/burping
- When to call physician
- How to take the baby's temperature.
- Bath Class
- Peri-Care
- Family Planning

B. Psychosocial discharge assessment will be done and documented in the chart.

C. Patient will sign and be given a copy of the Discharge Instructions Work sheet. Follow up appointments will be made for the mother and the baby.

D. All mothers will be educated to the advantages of breastfeeding their babies.

DISCHARGE:

Discharge of patient from FMC area will be by physician order. All patient teaching will be completed prior to discharge. Newborn Screening tests will be obtained on all newborns prior to discharge. Parents will be instructed to return for the second Newborn Screening Test. Birth Certificate information will be obtained prior to discharge. All infants will have a Newborn Hearing Screen done prior to discharge.

PHYSICIAN'S RESPONSIBILITIES:

Standardized orders, standing orders, and protocols are used in FMC for specific patient needs. Such orders are developed in collaboration with the medical and nursing staff.

References

Association of Women's Health, Obstetric and Neonatal Nurses. (2010) *Guidelines for Professional Registered Nurse Staffing for Perinatal Units.* Washington, DC: Author.