
DOCUMENTATION

Because pregnant, laboring, and postpartum females will by definition be going to different providers and sites of care, it is essential that accurate, complete, and relevant documentation occur throughout care. In particular, the usually frequent number of prenatal visits allows for a complete database. The American College of Obstetricians and Gynecologists (ACOG) Antepartum Record Form may be used, or another similar form. There are sections for documenting interview, assessment, laboratory, problem lists, progress notes, and education information.

SOAP notes commonly supplement the ACOG or prenatal flow sheet with information from the interview, laboratory and radiologic studies, and physical examination at every visit. Subjective information includes client reports of discomfort, questions, emergency visits for pregnancy or other problems, personal problems, or changes in family situation. Objective information includes vital signs, physical examination results, and laboratory and radiologic study results.

The assessment section of a SOAP note is the "diagnosis." Most of the 176 NANDA nursing diagnoses can have an obstetric application. See Appendix A for NANDA diagnoses.

For a midwife or nurse practitioner, the assessment section usually indicates the gestational age, and any problems or identified needs of the client, as well as differential diagnoses. The plan section for a nurse will include nursing interventions such as assessment, counseling, education, reassurance, and other therapeutic interventions within the nurse's scope of practice. A midwife or nurse practitioner additionally will include medical management plans, laboratory orders, sonograms as indicated, prescribed medications, and interval until next visit. The sharing of nursing and medical plans through complete documentation ensures continuity of care and is reassuring to the prenatal client.



Sample Narrative SOAP Note

The nurse returns to the prenatal clinic after a 2-week vacation. Prior to examining the next client, Bonita Ramirez, gestational age 25 weeks, the nurse reads the following note from 7 days previous:

Subjective:

Client reports severe cold symptoms including nonproductive cough, malaise, runny nose. Denies contractions, vaginal discharge, or bleeding.

Objective:

See flow sheet. Temperature 99.4—pulse 76—respirations 18—blood pressure 110/70. Throat pink, bilateral breath sounds clear.

Assessment:

IUF 24 weeks, size=dates, mild cold.

Plan:

Recommended rest, increased fluids, steam vaporizer, warm saline gargles three times daily, OTC dextromethorphan, acetaminophen. Glucose screen next visit. Return to office in 1 week. —C. Turner, CNM.

Upon greeting Ms. Ramirez, the nurse inquires as to the status of the cold symptoms, and prepares the client for administration of glucose screen. Through careful documentation, the nurse-midwife team is able to ensure the client is well cared for, and time-sensitive laboratory tests are administered at the correct time.

Prenatal charts are routinely copied throughout pregnancy and faxed or mailed to the planned site of birth. A copy of the chart should be at the delivery site by the middle of the third trimester (approximately 32 weeks). Electronic records may increase the availability of information when clients present for hospital care. In some offices and clinics, the client also carries a copy of her own prenatal record. Client involvement in recording weight, urine checks, and other routine measurements contributes to autonomy and empowerment, and cultivates a sense of responsibility for the pregnancy.