**POSTPARTUM ROUNDING**

*\* On the paper list of postpartum patients (often can be printed, depending on the site), you can write the patients' initials and room numbers as identifiers. If there are names or other identifying information, please make sure you discard the paper in a secure shredding box (often in Med Ed student centres or around the nursing stations).*

**ID:** age, GTPAL, PPD\_, type of delivery (CS, SVD, forceps, vacuum), complications (3rd/4th degree laceration, PPH)

**S: (head to toe screening)**

Most important questions for meeting discharge criteria:

* **Pain well controlled?** Analgesia use?
* **Tolerating PO intake?**
* **Voiding well?**
* **Passing flatus/BM?**
* **Ambulating?** Calf swelling?
* **Lochia within normal limits?** (bleeding - minimal, moderate, heavy?)

Nausea/vomiting?

Headache, visual changes

Chest pain/SOB?

Breastfeeding?

**O:**

General appearance, vital signs

Cardiorespiratory exam: if applicable

Abdominal exam: Uterine fundus (feel uterus around umbilicus, 1-2cm below/above), incision if applicable (look at dressing and see if soaked, dry blood, fresh blood etc.)

Perineum: typically not required but sometimes indicated; \*only perform with resident/staff

Calves: edema, erythema, tenderness

**Investigations:** POD#1 Hb level in C/S patients, PPD\_ Hb in PPH patients

**Assessment:** Well, recovering OR not well, complicated recovery - differential diagnosis if applicable

**Plan**: encourage ambulation, encourage PO intake, DAT, advance diet. Investigations. Outstanding goals required to meet for discharge.