Appendix U: Sample Nursing Management Policy and Procedure

Nursing Management of Preeclampsia
Sample Policy and Procedure

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PURPOSE:
To outline the nursing management of inpatients who have preeclampsia including special considerations for management of patients on magnesium sulfate, patients on antihypertensive medications and management of eclampsia.

BACKGROUND:
Preeclampsia is a hypertensive disorder of pregnancy characterized by vasospasm and endothelial damage, which may impact the cardiovascular, renal, hematological, neurologic, and hepatic systems as well as the uteroplacental unit. It is of unknown etiology. Preeclampsia is characterized by new onset of hypertension and proteinuria after 20 weeks gestation in a previously normotensive woman.

- Hypertension: two blood pressure reading of > 140 systolic OR > 90 diastolic taken at least six hours apart
- Proteinuria: 0.3 gm of protein in a 24 hour urine collection

REPORTABLE CONDITIONS:
Notify provider for:

1. Repeated blood pressure greater than 160 systolic OR greater than 105-110 diastolic (taken at least 15 minutes apart).
2. New or worsening complaint of any of the following:
   a. Headache
   b. Visual changes
   c. Right Upper Quadrant (RUQ) or epigastric pain
3. Abnormal lab values

ADMISSION:

1. Assess for absence or presence of:
   a. Headache
   b. Visual changes
   c. Right upper quadrant or epigastric pain
   d. Nausea/vomiting
   e. General malaise.
2. Assess upper or lower deep tendon reflexes.
3. Auscultate for lung sounds, noting any presence of rales, rhonchi, wheezing, etc.
4. Assess for generalized edema and significant, rapid weight gain.

5. Assess blood pressure using an appropriately sized blood pressure cuff with patient sitting or in the upright position with the patient's arm at the level of the heart. Do not reposition the patient to her left side and retake blood pressure. It will give a false lower reading.
6. Apply external fetal monitor (if viable fetus).
7. Prepare to obtain IV access as ordered by provider.
8. Prepare to administer medications to lower blood pressure and prevent seizure activity.
9. Prepare to monitor intake and output.
10. Maintain activity as ordered by provider. If on bedrest, maintain side-lying position as much as possible, avoiding supine position, and change position every two hours or more often as needed.
11. Provide emotional support and opportunity for patient family to verbalize questions, concerns and/or fears.
12. Assess maternal vital signs including: blood pressure as described above, respiratory rate, heart rate, temperature, and oxygen saturation.
13. Prepare to assess lab values as ordered.
14. Ensure oxygen and suction equipment are present and functioning.
15. Implement measures to decrease stress level, such as provision of a quiet environment and low lighting.
16. Monitor temperature per department protocol.
17. Assess intake and output (I&O) every 1 hour.

ANTEPARTUM ONGOING ASSESSMENT:

Goals of patient management are:

1. Early recognition of severe or worsening preeclampsia or development of eclampsia.
2. Prolongation of pregnancy to optimize fetal maturation must be weighed against risks of pregnancy continuation.

Preeclampsia without severe features (mild):

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 4 hours.
2. Assess lung sounds every 4 hours.
3. Assess deep tendon reflexes (DTRs), Clonus, edema, level of consciousness (LOC), headache (HA) visual disturbances, epigastric pain every 8 hours.
4. Obtain Non Stress Test (NST) or monitor Fetal Heart Rate (FHR) with uterine activity for 30 minutes every shift or as condition warrants.
5. Assess fetal movement every shift.

Severe Preeclampsia:

1. Obtain blood pressure, pulse, respirations, and oxygen saturation hourly.
2. Assess lung sounds every 2 hours.
3. Assess deep tendon reflexes (DTR's), Clonus, edema, level of consciousness (LOC), Headache (HA) visual disturbances, epigastric pain every 4 hours.

4. Monitor FHR and uterine activity continuously.

INTRAPARTUM ONGOING ASSESSMENT:

Preeclampsia without severe features (mild):

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 60 minutes.
2. Assess lung sounds every 4 hours.
3. Assess deep tendon reflexes (DTRs), clonus, edema, level of consciousness (LOC), headache (HA) visual disturbances, epigastric pain every 8 hours.
4. Monitor FHR and uterine activity continuously.

Severe Preeclampsia:

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 30 minutes.
2. Assess lung sounds every 2 hours.
3. Assess Deep Tendon Reflexes (DTRs), clonus, edema, level of consciousness (LOC), headache (HA) visual disturbances, epigastric pain every 4 hours.
4. Monitor FHR and uterine activity continuously.

POSTPARTUM TO DISCHARGE ONGOING ASSESSMENT:

Preeclampsia without severe features (mild):

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 4 hours.
2. Assess lung sounds every 4 hours.
3. Assess deep tendon reflexes (DTRs), Clonus, edema, level of consciousness (LOC), headache (HA) visual disturbances, epigastric pain every 8 hours.

Severe Preeclampsia:

1. Obtain blood pressure, pulse, respirations, and oxygen saturation every 60 minutes for first 24 hours after delivery then every 4 hours.
2. Assess lung sounds every 2 hours for first 24 hours after delivery then every 4 hours.
3. Assess deep tendon reflexes (DTRs), clonus, edema, level of consciousness (LOC), headache (HA) visual disturbances, epigastric pain every 4 hours.