PREGNANCY IN TRAUMA/CRITICAL ILLNESS – ICU/ED

PURPOSE: To outline the nursing management of the injured/critically ill pregnant patient.

SUPPORTIVE DATA:

Trauma is the leading cause of maternal death and involves both the mother and fetus. The treatment priorities for a pregnant patient are the same as for a non-pregnant patient. Interventions should be directed at stabilizing the mother because maternal death is the leading cause of fetal death.

Women greater than 20 weeks gestation should be maintained in the lateral position to avoid vena cava syndrome, which is associated with the supine position and causes hypotension.

The signs and symptoms (S/S) of maternal shock may be delayed due to an increase in maternal blood volume. Therefore, the fetus may be hemodynamically compromised despite normal maternal vital signs.

Fetal heart rate monitoring is indicated for the fetus greater than or equal to 23 weeks. Fetal heart rate should be between 110-160 beats/minute. In the ED, the RN should apply electronic fetal monitoring device, however the physician or Labor and Delivery RN is responsible for evaluating electronic fetal monitoring. In the ICUs, if continuous fetal monitoring is indicated, the L&D RN will bring and apply the monitors and evaluate. When fetal heart rate monitoring is used in a non-obstetric unit, a qualified individual who has passed the DHS Fetal Heart Rate Monitoring Exam should be readily available to interpret the fetal heart rate patterns.

INITIAL ASSESSMENT:

1. Assess upon admission:
   - Maternal vital signs (VS)
   - Fetal heart tones (FHT) via doppler/monitor
   - Presence/absence of:
     - Uterine contractions
     - Vaginal bleeding/fluid discharge
     - Fetal movement (greater than 16 weeks multipara; greater than 20 weeks primipara)
     - Abdominal pain
2. Obtain the following history upon admission:
   - Number of weeks pregnant/estimated date of delivery
   - Gravida, para, abortion status
   - Any complications of current/past pregnancies

ONGOING ASSESSMENT:

3. Assess the following a minimum of every 1 hour:
   - Vaginal spotting, bleeding, or fluid leakage
   - Uterine contractions, tenderness or pain
   - Abdominal guarding
   - FHTs (greater than 12 weeks gestation)
   - Maternal signs of hypovolemic shock:
     - Cool, pale, diaphoretic skin
     - Weak pulse, tachycardia, hypotension
     - Dizziness, lightheadedness
4. Evaluate labs as drawn.

COLLABORATION:

5. Consult with obstetrician/primary physician/NICU consult regarding impending labor/need for fetal monitoring.
6. Consult with Labor and Delivery Nurse regarding obstetric nursing management.

NURSING CARE:

7. Administer oxygen as ordered.
8. Maintain mother in left lateral position (if greater than 20 weeks gestation) as ordered.

- Place on left side (preferred method)
- If unable to place on left side, attempt one of the following:
  - Displace uterus to left manually (if hypotensive)
  - Place roll under right hip
  - Tilt backboard to left (if in spinal precautions)
  - Place on right side

9. Keep born out of asepsis (BOA) pack at bedside.
10. Call OB Team Assist (x111)

DELIVERY:

11. Do the following for live birth:
    - Assess color, heart rate, muscle tone
    - Dry, stimulate, suction
    - Initiate newborn resuscitation if needed

12. Do the following for infant delivered with no signs of life (absence of heart rate, respiratory effort and movement):
    - Refer to Perinatal Loss Nursing Clinical Standard
    - Less than 20 weeks gestational age, send to pathology
    - More than 20 weeks gestational: Register remains, place in shroud and send to morgue. Send placenta to pathology
    - If unsure of either age or weight, consult with OB/GYN Services (x92203)

REPORTABLE CONDITIONS:

13. Notify the physician for:
    - Deterioration in maternal VS
    - Signs/symptoms (S/S) of shock
    - S/S of fetal compromise:
      - Decrease in fetal movement as reported by mother
      - Fetal heart rate less than 110 or greater than 160
    - S/S of impending labor:
      - Presence of uterine contractions
      - Vaginal bleeding or fluid discharge
      - Back pain
      - Urge to move bowels
      - Fetal HR decelerations (Category II) as interpreted by L&D nurse

PATIENT/ FAMILY TEACHING:

14. Instruct on the following:
    - Need to report:
      - Decreased/absent fetal movement
      - Contractions
      - Abdominal pain/tenderness
      - Vaginal bleeding/fluid discharge
    - Purpose of:
      - Maternal/fetal monitoring
      - Maternal positioning

ADDITIONAL STANDARDS:

15. Implement the following as indicated:
    - Blood and Blood Products
    - Intravenous Therapy
    - Oxygen Therapy
    - Pain Management
    - Perinatal Loss
    - Guidelines for Fetal Heart Rate Monitoring, Policy #926

DOCUMENTATION:

16. Document in accordance with documentation standards
    - FHT is documented in iView, Vital Signs section

DATE APPROVED: 03/99
APPROVED BY: Professional Practice Committee
Nursing Executive Council
Attending Staff Association Executive Committee
REVISION: 11/00. 03/05, 1/10, 12/17