HYPERTENSION IN PREGNANCY

PURPOSE: To outline the management of the patient with Hypertension in Pregnancy.

SUPPORTIVE DATA: Preeclampsia is a pregnancy-specific hypertensive disease with multisystem involvement that usually occurs after 20 weeks gestation, most often near term and can be superimposed on another hypertensive disorder. Preeclampsia is defined by either a systolic BP of 140 mm Hg or greater, diastolic BP of 90 mm Hg or greater, or both on two occasions greater than 4 hours apart.

Proteinuria is defined as greater than or equal to 300 mg of protein in 24 hours excreted urine collection or a measured protein-to-creatinine single void ratio of equal to or greater than 3.

Preeclampsia with severe features is defined as systolic BP 160 mm Hg or greater or diastolic BP of 110 mm Hg or greater. In the absence of proteinuria, preeclampsia can also be diagnosed as hypertension in pregnancy when associated with thrombocytopenia, impaired liver function, new development of renal insufficiency, pulmonary edema or new-onset of cerebral or visual disturbances.

Gestational hypertension is considered part of the spectrum of hypertension in pregnancy and is defined by blood pressure elevation after 20 weeks of gestation in the absence of proteinuria or any of the aforementioned systemic findings.

ASSESSMENT:

1. Assess the following upon admission and a minimum of every 4 hours or as ordered by provider:
   - Vital Signs
     - Every hour (L&D)
   - Uterine contractions
     - Every hour (L&D)
   - Fetus
     - Fetal heart rate (greater than 12 weeks)
     - Presence of a Category I fetal heart rate tracing (L&D)
     - Fetal movement (greater than 20 weeks)
   - Neurologic changes – headache, visual changes [blurred or double vision, scotomata (spots before eyes)], seizure activity
   - Right upper quadrant and epigastric pain
   - Urine output
     - Preeclampsia with severe features or eclampsia – every hour
     - Preeclampsia – a minimum of every 6 hours
     - Antepartum – a minimum of every 8 hours
2. Assess for signs and symptoms (S/S) of magnesium toxicity:
   - Decreased or absent deep tendon reflexes
   - Respiratory depression
   - Chest pain
   - Muscle weakness
   - Lethargy

INTERVENTIONS:

3. Maintain ambulation and bathroom privileges, unless otherwise ordered.
4. Maintain bedrest in lateral position as ordered.
5. Administer magnesium sulfate as ordered.
6. Decrease environmental stimulation.
7. Send urine analysis as ordered.

SAFETY:

8. Ensure oxygen and suction equipment are available.
9. Implement seizure precautions as indicated

REPORTABLE CONDITIONS:

10. Notify the provider immediately for:
    - Change in VS per parameters as set by provider
    - Category II or Category III fetal heart rate tracing

- Tachysystole (greater than 5 uterine contractions in 10 minutes averaged over 30 minutes)
- Headache, visual changes, hyperreflexia, seizure activity
- Right upper quadrant and epigastric pain
- Urinary output less than 30 mL per hour
- Increase in proteinuria
- S/S of magnesium toxicity

PATIENT/ FAMILY TEACHING:

11. Instruct patient to notify nurse of the following:
    - S/S of worsening preeclampsia (headache, blurring vision, epigastric pain)
    - Shortness of breath, chest pain
    - Muscular weakness
    - Decreased or absent fetal movement

ADDITIONAL STANDARDS:

12. Refer to the following as indicated:
    - Antepartum Patient Management
    - Electronic Fetal Monitoring
    - Indwelling Bladder Catheter
    - Intravenous Therapy
    - Pain Management
    - Seizure Activity

DOCUMENTATION:

13. Document in accordance with documentation standards.
14. Document on Labor navigator band.

Initial date approved: 06/00	Reviewed and approved by: Department of Anesthesia Professional Practice Committee Nurse Executive Council Attending Staff Association Executive Committee	Revision Date: 08/02, 03/05, 10/19