NURSING

TITLE: Placenta Previa: Antepartum Unit

PURPOSE: To outline the long-term nursing management of patients with third trimester bleeding caused by placenta previa.

LEVEL: Interdependent (*requires M.D. order)

SUPPORTIVE DATA: Placenta previa occurs when the site of placental implantation covers all or a portion of the lower uterine segment, including the cervix. A complete placenta previa covers the entire internal cervical os. When only a portion of the os is affected, the previa may be referred to as:

- partial: the internal cervical os is partially covered
- marginal: an edge of the placenta lies at the border of the internal cervical os

Characteristics of placenta previa include painless bleeding without warning or trauma. Signs of labor may or may not be present. A placenta previa is potentially life threatening to the mother and fetus. Rapid blood loss may occur related to increased vascularity and peripheral blood flow in pregnancy. If cervical dilation occurs, the placental attachment tears away and bleeding occurs. For this reason, vaginal exams should be avoided.

The goals of management are to prevent bleeding and cervical dilation. Patients who have a complete placenta previa at the time of delivery require cesarean delivery; patients with partial or marginal placenta previas may be able to deliver vaginally.

ASSESSMENT:

1. Assess on admission and every 8 hours:
   - vaginal bleeding (amount, color, and presence of clots)
   - color, odor, and amount of vaginal discharge and/or amniotic fluid
   - presence of uterine contractions (frequency, duration, and quality)
   - abdominal tenderness
   - fetal activity
   - fetal heart rate (if ≥ 24 weeks)
     NOTE: Assess fetal heart rate daily if ≥ 12-23 weeks.
   - compliance with activity restrictions
2. Assess twice daily:
   - temperature
   - pulse
   - respiration
   - blood pressure
3. Assess patient/family response to hospitalization daily.
4. Assess weekly (on Wednesday)
   - weight
   - *urine protein

LABS:

5. Monitor results of lab tests:
   - CBC with platelets
   - coagulation studies, e.g. PT, PTT, fibrinogen

*6. Draw type and screen every 72 hours.

REPORTABLE CONDITIONS/ NOTIFY M.D.:

7. Notify physician for:
   - sudden onset of vaginal bleeding
   - vaginal bleeding > 1 pad/15 minutes
   - change in color/odor of vaginal discharge
   - rupture of membranes
   - uterine contractions ≥ 4/hour
   - abdominal tenderness
   - decreased fetal activity or kick counts <4 movements/hour
   - FHR or baseline > 160 bpm or <110 bpm, and/or presence of decelerations (FHR below baseline by ≥ 15 bpm x ≥ 15 sec.)
   - temperature > 37.6°C
   - pulse >120, B/P <90/50, respiration <10/minute
   - weight gain > 1 kilogram between successive weighings
   - proteinuria > 1+
   - patient/family inability to cope with hospitalization
   - noncompliance with activity restrictions

CARE:

*8. Perform external maternal/fetal monitoring according to UNC Hospitals Nursing protocol Monitoring: Maternal/Fetal: Antenatal Patients.

*9. Maintain IV medlock with 18 gauge catheter or larger.

10. Maintain patient on bedrest in left or right lateral positions.

11. Provide comfort measures.

12. Assist with diversional activities.

13. Provide diet as tolerated; encourage 8-10 glasses of fluid daily.

14. Provide measures to prevent constipation:
   - PO fluid intake
   - high fiber foods
   - prune juice/warm liquids
   - *medications

15. Encourage patient to verbalize anxiety and concerns about herself and the baby's condition.

16. Arrange a visit to NCCC by wheelchair or by stretcher (if patient's condition permits), or arrange visit by pediatrician/nurse.

EMERGENCY MEASURES:

17. In the event of hemorrhage:
   - notify M.D. immediately
   - check blood pressure, pulse and fetal heart rate immediately and every 15 minutes
   - stay with and reassure the patient
   - place patient in lateral position
   - *start IV of normal saline
   - *administer oxygen by tight face mask at 8-10 liters/min.
   - notify Labor and Delivery that patient is being transported to the Delivery Room

PATIENT/CAREGIVER TEACHING:

18. Explain to patient/caregiver:
   - cause and management of bleeding

- purpose of all procedures and tests
- rationale for maintenance of bedrest and lateral position

19. Instruct patient to report to nurse:
    - vaginal bleeding and discharge
    - abdominal pain
    - uterine tenderness or contractions $\geq$ 4 times/ hour
    - decreased fetal activity
    - rupture of membranes
20. Instruct patient/caregiver and reinforce as needed:
    - preparation for labor and delivery
    - preparation for Cesarean section
    - possible need for neonatal intensive care
    - use of antenatal steroids to enhance fetal lung maturity

DOCUMENTATION:

21. Document on Progress Notes, Patient Care Record/flowsheet or electronic form:
    - implementation of Placenta Previa: Antepartum Unit protocol
    - additional interventions
    - assessment findings
    - interventions and patient responses/outcomes
    - reported conditions
    - patient/caregiver teaching and level of understanding

REFERENCE:

Genovese, S.K. (2004). Antepartal hemorrhagic disorders. In D.L. Lowdermilk and S.E. Perry, *Maternity and Women's Health Care (8th ed.)* (pp. 860-880). St. Louis: Mosby.

Simpson, K.R. & Creehan, P.A. (2001). *AWHONN's Perinatal Nursing (2nd ed.).* Philadelphia: Lippincott.

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