

PROTOCOL FOR: Bleeding in the Third Trimester of Pregnancy

DESIRED

- PATIENT OUTCOMES:
1. Patient will experience reduction of vaginal bleeding and no significant blood loss.
 2. Patient will experience resolution of preterm labor, if applicable.
 3. Patient will maintain pregnancy with minimal or no complications to self and fetus.

CLINICAL
ASSESSMENT

AND CARE:

1. Elicit pertinent information from the patient about her bleeding and/or contractions i.e. what time it started, amount, activities just prior to incident, frequency of contractions.
2. Assess and record patient's baseline blood pressure and pulse.
3. Assess fetal heart rate baseline and variability and presence or absence of contractions by placing the patient on continuous electronic fetal monitoring. Reassess every 1-2 hours on patients with minimal or no active bleeding. In the presence of active and/or heavy bleeding, continually reassess the fetal heart rate baseline, variability, and the presence or absence of periodic changes.
4. Assess for active bleeding and initiate a peripad count. Note color and amount of bleeding (i.e., bright red, dark brown, saturation of the peripad). Any bloodstained peripads removed from the patient while in the hospital should be weighed for estimation of blood loss (1 gm = 1 cc).
5. Labs as ordered. Continuous maintenance of type and screen is recommended.
6. Begin tocolytic therapy as ordered and follow appropriate protocols.
7. Patients not on tocolytics should have vital signs and temperature taken every four hours unless active bleeding is present. If bleeding is present, vital signs should be taken a minimum of every two hours.
8. Administer betamethasone for fetal lung maturity as ordered.

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9. All patients diagnosed with third trimester bleeding shall have blood type and screens updated every 72 hours as per blood bank policy. Recheck maternal hemoglobin and hematocrit as ordered.
10. The stable patient may be transferred to OB-GYN for continued antepartum care and/or eventual discharge.

Upon transfer to OB-GYN:

1. Assess vital signs, fetal heart rate and fetal movement on admission and at least every 8 hours.
2. Assess for vaginal bleeding every 4 hours and prn.
3. Assess vaginal discharge for presence of amniotic fluid every 4 hours and prn.
4. Assess mother's ability to perceive contractions on admission and prn.
5. Assess presence of abdominal pain and/or tenderness every 4 hours and prn.
6. Activity restricted to bedrest with bathroom privileges, unless physician orders total bedrest or increased activity.
7. Regular diet with emphasis on good prenatal nutrition, high fiber and adequate fluids.
8. Administer daily meds, i.e. PNV, FeSO₄, as per MD orders.
9. Administer betamethasone, IM, weekly, as ordered.
10. NSTs as per MD order.
11. Fetal/uterine monitorings as necessary, for question of uterine contractions and/or change in maternal/fetal status.
12. Make appropriate referrals to support services as indicated.
13. Encourage and support maternal/fetal attachment.
14. While in OB-GYN, if bleeding reoccurs, the patient should be placed on an external fetal monitor to assess fetal well being and the presence or absence of uterine activity. As ordered, a heparin lock may be inserted or intravenous

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fluids begun. If bleeding continues, prepare the patient
for transfer to L&D.

REFERENCES: Nursing Standards Committee

EFFECTIVE DATE: 1/91

REVISION DATES: 8/91, 9/93, 3/97, 3/00

REVIEWED DATES: 9/08