PROTOCOL FOR: **Hypertensive Disorders of Pregnancy: Care of the Patient**

DESIRED PATIENT OUTCOMES:

1. Patient will verbalize an understanding of hypertensive disorder and the intended plan of care.
2. Patient will be free of or have minimal discomfort from antihypertensive medications and/or interventions.
3. Patient will be delivered, when appropriate, safely via either induction of labor or cesarean section.
4. Patient and fetus will have minimal or no complication during the delivery process.

CLINICAL ASSESSMENT AND CARE:

1. Assess maternal blood pressure on admission, at least every 4 hours and prn. Assess pulse, respirations, and fetal heart rate on admission, then at least every 8 hours or more often if necessary.
2. Assess the following symptoms on admission, every 4 hours and more often as changes become evident:

   a. headaches and/or visual changes
   b. epigastric pain

3. Assess the following symptoms on admission, every 8 hours and more often if necessary:

   a. edema
   b. reflexes/clonus
   c. proteinuria
   d. I+O

4. Assess patient's understanding of physiological changes associated with hypertension and effects of her hypertensive disorder on the fetus.
5. Assess patient's knowledge of antihypertensive treatment, anesthesia, modes of delivery, and the neonatal nursery (if applicable).

ANTEPARTUM CLINICAL CARE ON OB/GYN:

1. Activity restricted to bedrest with bathroom privileges unless otherwise ordered by physician.
2. Regular diet with emphasis on good prenatal nutrition, high fiber, and adequate fluids, unless otherwise ordered by physician.
3. Position patient as per MD orders for BP evaluation.
4. Fetal monitoring/antepartum testing, as ordered and prn.

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5. Obtain laboratory specimens as ordered by physician.

6. Make appropriate referrals to support services as indicated.

7. Encourage and support maternal-fetal attachment.

L&D CLINICAL CARE:

1. Place patient in left lateral position. Provide dim, quiet environment.

2. Apply external fetal monitor.

3. Vital signs should be obtained every 1-2 hours, more often if necessary, i.e. unstable BPs, with each increase of Oxytocin (as per protocol).

4. Check reflexes and clonus every 2 hours.

5. Begin magnesium sulfate as ordered.

   a. Obtain baseline vital signs.
   b. Obtain deep tendon reflexes prior to administration.
   c. Assure that calcium gluconate is available on the unit as a magnesium sulfate antidote.
   d. Place an indwelling catheter as ordered (remove when those patients having a vaginal delivery are fully and pushing).
   e. Reassess vital signs at the end of the loading dose and at least every two hours during magnesium sulfate therapy.
   f. Draw labs as ordered.

6. Siderails must remain up at all times.

7. If induction of labor is planned, begin Oxytocin as ordered, following appropriate protocol.

8. If cesarean section delivery is planned, prepare the patient for surgery.

9. Administer additional antihypertensives to control BPs as ordered by physicians following the appropriate protocols.

10. Assist physician or anesthetist with placement of invasive monitoring devices if indicated, i.e. central venous line, arterial line, Swan/Ganz catheter.

11. Discuss with patient the plan of care following delivery. Encourage patient and support person to keep visitors to a minimum during labor and recovery period. Explain that the RN will restrict visitation if visitors are too numerous and/or too frequent.

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12. Following delivery, the patient may receive magnesium sulfate therapy for 24 hours postpartum.

13. Following delivery, update patient on infant's condition as necessary.

APPROVAL: Nursing Standards Committee

CREDENTIALS: RN

EFFECTIVE DATE: 1/79

REVISION DATES: 12/90, 5/92, 8/93, 3/97, 3/00, 3/09