# Placenta Previa

This program is designed for the second semester student caring for a non stable Obstetrical patient with placenta previa. Incorporated are the skills and medications necessary for caring for the obstetrical patient and the recognition of the possible implications of placenta previa.

Objectives:

1. Assessment and recognition of the signs and symptoms of an obstetrical patient with placenta previa
    a. Assess for hemorrhaging
    b. Assess for anxiety related to fetal status
    c. Assess for changes in cognitive of lethargy and/or confusion
    d. Assess vital signs
    e. Assess for knowledge deficit related to placenta previa
2. Initiate interdisciplinary collaboration in a hospital setting
    a. Report changes in the patient's condition to the physician
    b. Implement new orders from physician
    c. Chart findings on appropriate charting sheets
3. Select appropriate interventions
    a. Start an IV
    b. Do vital signs
    c. Have patient sign a consent form
    d. Administer medications
    e. Prepare for a c section
4. Monitor therapeutic response to interventions (outcomes)
    a. Monitor amount of blood loss infection
    b. Monitor mentally alert and oriented
    c. Monitor that vital signs remain stable

Case Study: Noelle Sims is a 26 year old G2, P1 (2004) who is 37 weeks gestation. She awakened at 0200 thinking that she had wet the bed. When she arose she discovered her bed was covered in bright red blood. She called her obstetrician who directed her to go directly to the hospital. She was admitted to your labor and delivery unit with the admitting diagnosis of placenta previa.
Obstetrical History: This pregnancy has been uneventful up until this time. Her past pregnancy was also uneventful and she had a healthy 2681 gram baby girl.

What would you assess first?

What would be one of the first questions you would ask?

What would you not do?

After recording your assessment data (from your facilitator) proceed with your care.

# Clinical Learning Center Simulation Order

| | | |
|---|---|---|
| | | Name: Noelle Sims DOB: 9/17/81 |
| DATE | TIME | |
| | | ADMIT TO: ☒Labor and Delivery ☐Women's Health |
| | | DIAGNOSIS: ☐ Term labor l, ☐ premature labor, ☐C-section, ☒placenta previa, ☐abruptio placenta, ☐ Other_____ |
| | | ALLERGIES: ☐No ☒Yes If yes, list: latex |
| | | ACTIVITY: ☒ Bedrest ☐ BRP ☐ Activity as tolerated ☐ Other:<br>☐ I & O |
| | | VITAL SIGNS: ☐ Every 4 hours ☐ Every shift ☒ Other: every 2 hours<br>☐O2 Sats. Q shift ☒ Fetal Heart sounds every 2 hours |
| | | DIET: ☐NPO ☐2gm Low Na, low fat, ☐1800kcal ADA, ☐2000kcal ADA<br>☐ Other _____ |
| | | ☐ IV: Saline Lock ☐ D51/2NS with 20mEq KCL TRA _____<br>☒ 0.9% Sodium Chloride IV TRA 75 ml per hour ☐ Lactated Ringers TRA _____<br>☐ Other: _____ |
| | | $O_2$: ☐ None ☐ 2Liters/minute via Nasal Cannula ☐ Other: _____<br>☐ titrate to keep sats > 90% |
| | | MEDICATIONS:<br>☐ Aspirin non enteric coated 325 mg po daily<br>☒ Acetaminophen 650mg po q 6 hours prn pain or temp > 101.5 F.<br>☐ laxative of choice<br>☐ Zolpidem 5 mgs prn HS<br>☐NS 5mL IV BID and prn for IV flush<br>Others_____<br>Betamethasone 2 mg IM daily<br>Folic acid 0.5 mg po daily<br>_____ |
| | | (Treatments) ☐ Place Foley to DD<br>☐Dressing Changes _____<br>☐ Place NG Tube<br>☐ Other _____ |
| | | LAB TESTS:<br>☒ CBC ☐ Chem 7 ☒Routine UA<br>☐ Others_____ |
| | | ☐ Other tests: |
| | | Schedule for a c-section two days from admission<br>Any increased bleeding or contractions call physician immediately |

Date_____ Time_____ Signature: *Dr. Nate Early MD*

| MEDICAL RECORD | REPORT OF MEDICAL HISTORY | Date of Exam |
|---|---|---|

**Note: This information is for official and medically-confidential use only and will not be released to unauthorized persons.**

| 1. Name of Patient (First, Middle, Last) | 2. Identification Number | 3. Date of Birth |
|---|---|---|
| Noelle B Sims | 00123456526 | 9/17/81 |

| 4a. Home street address (Street, City, State, and Zip Code) | 5. Examining Facility |
|---|---|
| 1704 Childers Drive | Butler Community College<br>Simulation Hospital |

| 4b. City | State | Zip Code |
|---|---|---|
| Yourtown | KS | 67042 |

6. Purpose of Visit to the Hospital

Vaginal bleeding

7. Statement of Patient's Present Health and Medications Currently Used

| a. Present Health | b. Current Medications at Home |
|---|---|
| Good | Prenatal vitamin once a day |

| c. Allergies (include medications, latex, bee stings, and foods) | d. Height | e. Weight |
|---|---|---|
| latex | | |

| 8. Patient's Occupation | 9. Are you: (check one) |
|---|---|
| | ___ Right Handed ___Left Handed |

10. Past/Current Medical History

| Check Each Item | Yes | No | Don't Know | Check Each Item | Yes | No | Don't Know | Check Each Item | Yes | No | Don't Know |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Household Contact with anyone with tuberculosis | | x | | Shortness of Breath | | x | | Bone or join deformity | | x | |
| Tuberculosis or positive TB test | | x | | Pain or Pressure in chest | | x | | Loss of finger or toe | | x | |
| Blood in Sputum or when coughing | | x | | Chronic Cough | | x | | Painful shoulder or elbow | | x | |
| Excessive bleeding after injury or dental work | x | | | Palpitation or pounding heart | | x | | Recurrent back pain or any back injury | | x | |
| Suicide attempt or plans | | x | | Heart trouble | | x | | Knee injury | | x | |
| Sleepwalking | | x | | High blood pressure | | x | | Foot trouble | | x | |
| Wear corrective lenses | | x | | Low blood pressure | | x | | Nerve injury | | x | |
| Eye surgery to correct vision | | x | | Cramps in your legs | | x | | Paralysis | | x | |
| Complete vision loss in either eye | | x | | Frequent Indigestion | | x | | Epilepsy or seizure | | x | |
| Wears a hearing aid | | x | | Stomach, liver, or intestinal trouble | | x | | Car, train, or sea sickness | | x | |
| Stutters or Stammers | | x | | Gall bladder trouble | | x | | Frequent trouble sleeping | x | | |
| Wears a brace or back support | | x | | Jaundice or Hepatitis | | x | | Depression or excessive worry | | x | |
| Scarlet fever | | x | | Broken bones | x | | | Loss of memory | | x | |
| Rheumatic fever | | x | | Skin diseases | | x | | Nervous trouble of any sort | | x | |
| Swollen or painful joints | | x | | Tumor, growth, cyst, or Cancer | | x | | Periods of unconsciousness | | x | |
| Frequent or severe headache | | x | | Hernia | | x | | Parent/sibling with diabetes, cancer, stroke or heart disease. | x | | |
| Dizziness or fainting spells | | x | | Hemorrhoids or rectal Disease | | x | | | | | |
| Eye Trouble | | x | | Frequent or painful urination | | x | | X-Ray or other radiation therapy | | x | |
| Hearing Loss | | x | | Bed wetting since age 12 | | x | | Chemotherapy | | x | |
| Recurrent ear infections | | x | | Kidney stones or blood in urine | | x | | Asbestos or toxic chemical exposure | | | |
| Chronic or frequent colds | | x | | Sugar or Protein in urine | | x | | Plate or pin in any bone | | x | |
| Severe tooth or gum trouble | | x | | Sexually transmitted disease(s) | | x | | Been told to cut down or criticized for alcohol use | | x | |
| Sinusitis | | x | | Recent gain or loss of weight | | x | | | | | |
| Hay Fever or allergic rhinitis | | x | | Eating Disorder | | x | | Easily fatigued | | x | |
| Head injury | | x | | Arthritis, Rheumatism, or Bursitis | | x | | Used illegal substances | | x | |
| Asthma | | x | | Thyroid trouble | | x | | Used tobacco | | x | |

| Female patients | | | | | | |
|---|---|---|---|---|---|---|
| Check each item | Yes | No | Don't Know | Date of last menstrual period | Date of last pap smear | Date of last mammogram |
| Treated for a female disorder | | x | | 4/07 | 6/07 | NA |
| Change in menstrual pattern | x | | | | | |

Check each item. If "yes," explain in blank space to right. List explanation by item number.

| 12. Obstetric patients | Number | |
|---|---|---|
| Gravida | 2 | |
| Para | 1 | |
| If any problems with pregnancies list on right | | X |
| Item | Yes | No |
| 13. Have you ever been treated for a mental condition? (If yes, describe and give age at which occurred.) | | x |
| 14. Have you ever been denied life insurance? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) | | x |
| 15. Have you had, or have you been advised to have, any operation? (If yes, describe and give age at which occurred.) | | x |
| 16. Have you ever been a patient in any type of hospital? (If yes, specify when, where, why, and name of doctor and complete address of hospital.) | | x |
| 17. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? (If yes, give complete address of doctor, hospital, clinic, and details.) | | x |
| 20. Have you ever received, is there pending, or have you ever applied for pension or compensation for existing disability? (If yes, specify what kind, granted by whom, and reason.) | | x |

23. List all immunizations received
MMR, polio, Hepatitis B, TD

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I authorize any of the doctors, hospitals, or clinics and their staff that are directly providing management of my care to review and input data into the Medical Record in accordance with local, state, and federal laws.

| 24a. Typed or Printed Name | 24b. Signature | 24c. Date |
|---|---|---|
| Noelle Sims | *Noelle Sims* | |

NOTE: THIS DOCUMENT WILL BE PLACED IN THE MEDICAL RECORD

25. Physician's summary and elaboration of all pertinent data.
Placenta Previa plan c section in 48 hours

| 26a. Typed or Printed Name of Physician or Examiner | 26b. Signature | 26c. Date | Patient Label Here |
|---|---|---|---|
| Dr. Nate Early | *Dr. Nate Early MD* | | |

NURSING STATION WORKSHEET (MAR FORMAT)

| ROOM-BED | PATIENT | WT | AGE/SEX | ADM DATE | ATTENDING PHYSICIAN |
|---|---|---|---|---|---|
| B1 | **Noelle Sims** | 73 kg | 26/F | | Dr. Nate Early |

DRUG ALLERGIES: Ativan

| MEDICATION | ROUTE/SIG | ORDERING PHYS/DOSE | 0800-1559 | 1600-2359 | 0000-0759 |
|---|---|---|---|---|---|
| Betamethasone sodium phosphate | IM | 2 mg | 0900 | | |
| Folic acid | PO | 0.5 mg | 0900 | | |
| Acetaminophen | PO | Q 6 hr. prn pain or temp . 101.5 F | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Signature/Initials

_____/_____ _____/_____
_____/_____ _____/_____
_____/_____ _____/_____
_____/_____ _____/_____

Facilitator

Assessment findings:

Vital signs: T 98.6 F, P 84, R 20, BP 126/74

Fetal Heart Rate: Baseline 146 average

Uterine Activity: No uterine activity at this time

Vaginal Exam: deferred due to moderate-large amount of bright red, painless Bleeding

Scenario References

Black, J. & Hawks, J (2005) Medical Surgical Nursing Clinical Management for Positive *Outcomes* 7th ed. Elsevier Saunders, St Louis

Hopper, J. & Vallerand, A (2005) Davis's Drug Guide for Nurses 10th ed. F.A. Davis, Philadelphia

Palm Skyscape (2006) Drug Guide Skyscape, Inc.

Potter, P. & Perry, A. (2007) Basic Nursing Essential for Practice 6th ed. Mosby Elsevier, St. Louis

Reviewed and edited by Faculty at Butler community College