Section:	Division of Nursing	************ * **PROTOCOL** * ************	Index:	7010.028b
			Page:	1 of 2
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HACKETTSTOWN REGIONAL MEDICAL CENTER

Revised By: E. Mitro, RN
Reviewed By: P. Swanson, RN, BSN

ED
(Scope)

TITLE: **SPONTANEOUS ABORTION PROTOCOL**

PURPOSE: To outline nursing responsibility in caring for the ER patient with possible spontaneous abortion.

LEVEL: ___ Dependent ____ Interdependent ___ Independent

SUPPORTIVE DATA: Spontaneous abortion is the unintended termination of pregnancy at any time before the fetus has attained viability (20 weeks with gestation or fetal weight of more than 500 grams).

TRIAGE: Any female of childbearing age < 20 weeks pregnant with complaint of cramping, vaginal bleeding, abdominal pain will be triaged by RN to GYN Room. > 20 weeks will go to L&D directly.

Classification: hemodynamically stable: Urgent
hemodynamically unstable: Emergent

EQUIPMENT:
1. Gloves
2. Speculum
3. Lubricant
4. Light Source

PATIENT OUTCOME: The patient will remain hemodynamically stable as evidenced by normal/improved vital signs, fear and anxiety is minimized, and pain is minimized.

CONTENT:

ASSESSMENT	INTERVENTIONS
1. Assess for signs and symptoms of shock.	a. Obtain vital signs including temperature, heart rate and BP. - Pulse ox
	b. Administer 0_2 as needed in response to patient's vital signs.
2. Assess for presence of fetal heartbeat if patient is > 12 weeks pregnant.	a. Call OB Unit for OB RN to be in attendance if needed.
3. Determine patient's reproductive history.	a. Last menses. Determine whether a positive pregnancy test has previously been obtained.
	b. Number of pregnancies to term, abortions, live births.

4. Determine blood loss.
   a. Number of pads used, per hour.
   b. The onset of bleeding (note color and presence/absence of clots).
   c. Draw appropriate blood work as per physician (i.e., CBC with diff. serum preg., type and crossmatch, BMP.)
   d. Start large bore IV with appropriate fluid as ordered by ED MD.

5. Assess patient's pain.
   a. Location
   b. Onset
   c. Duration
   d. Description (i.e., sharp, dull)
   e. Administer pain med. as ordered and needed.
   f. Monitor level of pain or contractions closely, especially if on Pitocin. Adjust IV accordingly.

6. Prepare patient for pelvic exam.
   a. Assist physician.
   b. Offer emotional support.
   c. Insert foley catheter or prepare patient for ultrasound if needed.
   d. Save any tissue in saline - label and send with patient to O.R.

7. Start admission process.
   a. See prep for emergency surgery procedure.

8. Assess level of anxiety.
   a. Act in calm and reassuring manner. Stay with patient as much as possible.
   b. Allow family member to be with patient.
   c. Encourage patient to verbalize thoughts, feelings, questions
   d. Help translate MD instructions to simple, easy terms.
   e. Offer Chaplain support if requested.

DOCUMENT:

1. To protocol.
2. Chart deviations from protocol.
3. Response to procedures.
4. Response to pain medication.
5. Disposition of patient.

REFERENCE:

Lippincott Manual of Nursing Practice, 8th Edition, 2006.