Standards of Care for the Obstetric Patient

The following standards regard the care of the Obstetric patient admitted to the Critical Care Unit.

Objectives

*The patient will:*

1. Maintain adequate gas exchange for both mother and fetus.
2. Maintain adequate tissue oxygenation for both mother and fetus.
3. Maintain adequate tissue perfusion for both mother and fetus.
4. Maintain adequate cardiac output and perfusion for both mother and fetus.
5. Be free of or have minimal complications.
6. The safety and well being of both the mother and fetus will be preserved unless the staff physician declares the fetus nonviable.
7. Have reduced stress, along with family and significant others, through visitation and education of disease processes.

Care

- The ICU staff physician will be the primary care giver of the obstetric patient. The Obstetric service will be consulted and play an important role in the care of the obstetric patient.
- An ICU RN will care for the patient. If the patient is in or has a potential for active labor a labor unit RN will assist the ICU RN with the care of the patient.
- Patients may be placed in MICU 7J – 19 and SICU 3J - 10 for remote Labor and Delivery monitoring.
- An ICU RN performs primary care for the patient.
- If delivery anticipated, a NICU and or Labor Unit RN will be present.

Process Standards for the Obstetric Patient

*The ICU RN will:*

1. A complete head to toe assessment will be made and documented. This assessment should be repeated at least every 4 hours and as needed.
2. Notify ICU physician and Labor Unit RN if contractions noted.
3. Maintain continuous pulse oximetry and cardiac monitoring.
4. Notify the physician for abnormal pulse oximetry results. Oxygen saturation below 95% will be considered abnormal and will be addressed by the physician.
5. Blood pressure must be assessed and documented at least every hour. If Arterial Line present continuous monitoring of blood pressure will be present.
6. Ensure presence of fetal protection during chest or any other x-rays.
7. Be present for x-rays performed. Proper shielding shall be done when possible.
8. Be present for any procedure performed.
9. Ensure proper turning and positioning of the obstetric patient.
   a. Patient will be kept out of Supine position when possible to prevent vena-caval syndrome.
10. Document intake and output hourly and notify physician if <0.05cc/kg.
11. Assess skin initially including color, temperature, moisture, and signs of breakdown. This assessment shall be repeated every 4 hours.
13. Assess neurological status initially, including pupil size and symmetry, response to light, patient response to verbal and/or noxious stimuli, and patient movement of extremities. Document and repeat assessment every 4 hours or as needed.
14. Ensure presence of optimal sedation if neuromuscular blockers are used, and titrate sedation according to RASS as ordered by the ICU physician.
15. Obtain and document hemodynamics/minimally invasive hemodynamic values if devices present every 4 hours or more if indicated and notify MD of significant changes. If continuous device present, the nurse shall document continuous hemodynamic data hourly. Oxygenation profiles should also be done as needed to assess oxygen delivery and consumption.
16. Ensure presence of continuous cardiac monitoring.
17. Document cardiac rhythm initially and every 4 hours. A rhythm strip shall be placed in the graphics section of the chart every 12 hours or as needed.
18. If Fetal Heart tone monitor present, recording of strips should be documented as ordered by the ICU physicians with the guidance of the consulting Obstetric service. The Labor Unit RN will document the fetal tracing results in STORK.
   a. If Fetal Heart Tone monitor not present Fetal Heart Tones will be obtained and documented at least every shift for non – viable pregnancies and continuous monitors maybe placed on patients with viable pregnancies at the discretion of the OB Resident.
19. Ensure maintenance and dosage of all continuous vasoactive medications. Document dosages of all continuous vasoactive medications initially and with any change in dosage. All vasoactive medications are based mcg/kg/min. All continuous vasoactive medications will be controlled by an IVAC pump.
20. Obtain all lab studies ordered and document results in timely manner. A physician will by notified of all results.
21. ICU physician should be notified when the presence of the consulting Obstetric service is assessing the patient and recommendations should be noted.
22. Assure the presence of an emergency precipitous tray at the bedside at all times. An emergency cesarean cart will be available on the unit.
23. Administer all medications in timely manner and document patient effect.
24. Inform and update family and significant others of patient status at visitation times or as needed.
If Delivery anticipated by vaginal delivery the ICU RN will:

1. Notify ICU staff physician, the Obstetric service, Labor Unit, and NICU.
2. Have Respiratory Therapy at bedside for airway management. The patient will receive 100% FIO2 throughout the delivery.
3. Assure the presence of a continuous fetal heart tone monitor prior to delivery time to assess contractions and fetal heart rate.
4. Assure the presence of all needed infant supplies (should be brought to the unit and is the responsibility of the NICU).
5. Assure the presence of all needed delivery supplies (should be brought to the unit and is the responsibility of the Labor Unit).
6. Assure presence of emergency C-section tray.
7. Coordinate with the Labor Unit if the patient is to come there for the emergent procedure.
8. Assess and document patient status including all vital signs at least hourly throughout delivery.
9. The Labor Unit RN will assess, care and document as needed throughout the procedure regarding all obstetric matters. Both the ICU and Labor Unit RN may chart on the Critical Care flow sheet.
10. Once the baby is delivered, the infant is cared for by the NICU or Labor Unit staff. The ICU/Labor Unit RN will document needed information regarding transfer of the infant to nursery or NICU.
11. Explains, informs and updates patient condition to family and significant others at visitation or as needed.

If C-section anticipated the ICU RN will:

1. Notify ICU staff physician, the Obstetric service, Labor Unit, Nursery and or NICU.
2. Have Respiratory Therapy at bedside for airway management.
3. Assure the presence of a continuous fetal heart tone monitor prior to delivery time to assess contractions and fetal heart rate.
4. Assure the presence of all needed infant supplies (should be brought to the unit and is the responsibility of the NICU).
5. Assure the presence of all needed delivery supplies (should be brought to the unit and is the responsibility of the Labor Unit).
6. Assure presence of emergency C-section tray.
7. Terminally clean the procedure room (MICU)/notify OR (SICU) and prepare the room in case needed for c-section.
8. Transport the patient to the procedure room/OR suite in a timely and safe manner. If the patient is on the ventilator 100% FIO2 will be given and transported on the ventilator to the procedure room if needed.
9. Assess and document patient states including all vital signs at least hourly throughout delivery.
10. The Labor Unit RN will assess, care and document as needed throughout the procedure regarding all obstetric matters. Both the ICU and Labor Unit RN may chart on the Critical Care flow sheet.

11. Once the baby is delivered, the infant is cared for by the NICU or Labor Unit Staff. The ICU/Labor Unit RN will document needed information regarding transfer of the infant to nursery or NICU.

12. Explains, informs and updates patient condition to family and significant others at visitation or as needed.

13. Transports the patient back to the ICU room.

14. Calls for Housekeeping to clean the procedure room.

Post-Delivery the ICU RN will:

1. Assess and care for the patient as all other ICU patients.
2. Assess or ask the Labor Unit RN to assess the Fundus as ordered by the physician.
3. Assess lochia and vaginal discharge.
4. Assure presence of breast binding if needed.
5. Inform the physician of any excessive bleeding.
6. Update the patient on infant status as needed.

References: