

Elective Termination

Therapeutic abortion may be done to safeguard the woman's health, or a voluntary abortion may be a woman's reproductive decision.

CLIENT ASSESSMENT DATA BASE

Circulation

Preexisting maternal health problems placing client at risk

Ego Integrity

Pregnancy often unplanned; may be result of incest/rape.

May express concern about decision and future expectations.

Possible feelings of abandonment, i.e., loss of contact with male partner.

Stress factors may include inadequate finances, cultural/religious conflicts, and individual plans for the future.

May have strong feelings/beliefs regarding abortion that may be in conflict with present situation (e.g., conception is result of incest or rape); lack of support, or family/other pressures to have abortion.

Food/Fluid

Severe nausea and vomiting

Safety

History of pelvic inflammatory disease, STDs, or exposure to contagious diseases, such as rubella

Exposure to toxic/teratogenic agents

Sexuality

Lack of, or inadequate use of, birth control measures.

Menstrual history may include problems such as endometriosis, heavy flow, or irregular periods.

Uterus may be in extreme flexion or version.

Absence of adnexal masses (rules out ectopic pregnancy).

Vaginal bleeding may be present.

Social Interaction

Possible lack of support systems or conflict within the family/couple.

Teaching/Learning

Family history of genetic conditions.

Client's perception of reasons for pregnancy termination, influencing factors, and anticipated effects may/may not be clear; alternatives may not have been considered/discussed or explored.

DIAGNOSTIC STUDIES

Complete Blood Count (CBC), Blood Type, and Rh Determination: Identifies individual needs.

Urine or Radioimmunoassay of Serum for Human Chorionic Gonadotropin (HCG): Verifies pregnancy.

Papanicolaou Smear: Rules out dysplasias.

Gonorrheal Culture, Rapid Plasma Reagin (RPR): Determine presence of STD.

Ultrasonography: May be done to confirm the pregnancy, to date the pregnancy, or to localize the placenta, if there is some discrepancy between uterine size and estimated date of birth.

Genetic Testing/Screening: Identifies affected fetus, which may be reason for decision to terminate pregnancy.

NURSING PRIORITIES

1. Evaluate biopsychosocial status.
2. Promote/augment coping strategies.
3. Provide emotional support.
4. Prevent postprocedural complications.
5. Provide appropriate instruction/information.

DISCHARGE GOALS

1. Free of complications following procedure
2. Coping effectively with situation
3. Specific therapeutic needs and concerns understood

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION

CRITERIA—CLIENT WILL:

Decisional Conflict, risk for

Unclear personal values/beliefs, lack of experience or interference with decision making, lack of relevant sources of information or information from multiple or divergent sources, support system deficit

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Acknowledge feelings of anxiety/distress related

to making difficult decision.

Verbalize confidence in the decision to terminate the pregnancy.

Meet psychological needs as evidenced by appropriate expression of feelings, identification of options, and use of resources.

Display relaxed manner and/or calm demeanor, free of physical signs of distress.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Ascertain circumstances of conception and response of family/significant other. Encourage client to talk about the issues and process used to problem-solve and make decision regarding termination.

Note expressions of indecision and dependence on others.

Assist client to look at alternatives and use problem-solving process to validate decision. Involve significant others as appropriate.

Allows the nurse to determine whether the client/couple has explored alternatives. The decision to terminate a pregnancy may have been based on an inability to problem-solve or a lack of support and resources.

May indicate ambivalence about decision and need for further information and discussion.

Helps client to reinforce reasons for decision and to be comfortable that this is the course she wants to pursue.

Provide explanations about the procedure desired by the client, pre-procedural and post-procedural tests, examinations, and follow-up.

Evaluate the influence of family and significant other(s) on the client.

Remain with the client during examinations and the procedure. Provide both physical and emotional support.

Act as a liaison and lend support to significant other(s).

Collaborative

Review safe options available based on gestation.

Obtain/review informed consent.

Refer for additional counseling or resources, if needed.

Lack of knowledge about the procedures, reproduction, or self-care may contribute to the client's/family's inability to cope positively with this event, which may be behaviorally manifested by the client canceling appointments or verbalizing ambivalence. By eliminating fear of the unknown and by reinforcing reasons for and appropriateness of decision, ongoing verbalization can foster positive decision making.

Conflict can arise within the client herself as well as within the family. Allows the nurse to encourage positive forces or provide support where it is lacking.

Physical presence of nurse can help client feel accepted and reduce stress.

Helps reduce stress and encourages significant other(s) to be supportive of the client.

Assists client in making informed decision.

Depends on agency guidelines. No procedure should be performed unless the client freely consents to it.

Some clients may be more affected by the decision and may require additional support and/or education or genetic counseling.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Knowledge deficit [Learning Need], regarding reproduction, contraception, self-care, Rh factor

Lack of exposure/recall or misinterpretation of information

Request for information, statement of misconception, inaccurate follow-through of instructions, development of preventable events/complications

Verbalize accurate information about the reproductive system.

Explain proper use of desired contraceptive methods.

Demonstrate appropriate follow-through with treatment and aftercare.

Receive Rh₀(D) immune globulin within 72 hr of termination, if appropriate.

Verbalize the implications of the Rh factor for planning future pregnancies or for receiving blood transfusions.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess level of client knowledge, and provide information about reproduction. Use charts and diagrams.

Knowledge is essential to prevention of future unplanned pregnancies. Written and visual materials are more concrete and easily understood.

Discuss alternative methods of contraception.

Client needs information to be able to choose a method that is right for her. Ovulation may occur before menses resume, so contraception needs to be considered at this time.

Give specific instructions, preferably written, about the contraceptive chosen.

Client may have a method of contraception prescribed prior to discharge. Because of the anxiety and stress associated with the termination, verbal information may not be retained.

Reinforce postabortion instructions concerning the use of tampons and resumption of sexual activity, exercise, and prescribed antibiotics, if applicable. Provide written instructions.

The stress/anxiety caused by the procedure can diminish the client's ability to retain information. Written instructions can be reviewed when necessary. Note: Specific time frames vary according to practitioner.

Provide information about the implications of Rh_o(D)-negative blood and the need for RhIgG administration.

The client may not be aware of her blood type or the implications for future pregnancies if she is Rh_o(D)-negative. Understanding may promote positive self-care, enhance cooperation, and help prepare client for future pregnancies.

Identify signs/symptoms to be reported to healthcare provider.

Prompt evaluation/intervention may prevent or limit complications.

Collaborative

Verify Rh-negative status and administer RhIgG. Give 50 mg for early abortion; otherwise, dosage is the same as for delivery or fetal hemorrhage in the nonsensitized client.

For the Rh_o(D)-negative client, RhIgG prevents anti-Rh-positive antibody formation, so that negative effects on future pregnancies are avoided. Microdoses are given for early abortions, and this dose is sufficient up to 12 weeks' gestation. Fetal RBCs may be noted as early as 38 days after conception.

NURSING DIAGNOSIS:

Spiritual Distress (distress of the human spirit), risk for

Risk Factors May Include:

Perception of moral/ethical implications of therapy

Possibly Evidenced By:

[Not applicable; the presence of signs/symptoms establishes an *actual* diagnosis]

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Discuss beliefs/values about spiritual issues.

Verbalize acceptance of self/decision.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note comments indicating feelings of guilt, negative self-concept/self-esteem, and ethical or religious value conflicts.

Discuss alternatives to abortion with the client and significant other(s), if present. Maintain nonjudgmental attitude.

Assist with problem solving within the client's ethical and religious framework.

Support the client's decision.

Explain the grief response that may occur.

Stress the importance of follow-up visits.

There may be conflict with family/significant other(s) regarding the morality of the client's decision, which can create confusion for the client.

A decision based on a rational choice is less likely to result in conflict.

The ability to project the consequences of a decision or to explore alternatives may be hampered by anxiety and emotion.

Client may have few, if any, support systems available at this time and may need a nonjudgmental resource.

Client may not expect to feel loss.

There may be delayed psychological reactions, which can be assessed at the follow-up visit along with the physical status.

Collaborative

Refer to clergy/spiritual advisor, or professional counseling. (Refer to CP: The High-Risk Pregnancy; ND: Coping, Individual/Family, ineffective.)

Some clients may need additional counseling before and after abortion to help them resolve feelings of conflict or guilt.

NURSING DIAGNOSIS:

Anxiety [specify level]

May Be Related To:

Situational/maturational crises, unmet needs, unconscious conflict about essential values/beliefs

Possibly Evidenced By:

Increased tension, apprehension, fear of unspecific consequences, sympathetic stimulation, focus on self

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Recognize the presence of anxiety.

Identify the cause of anxiety.

Begin to use positive coping strategies to adjust to the situation.

Report anxiety reduced to a manageable level.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Acknowledge the client's anxiety. Encourage ventilation of feelings.

Client may need assistance in recognizing reactions.

Be empathic and nonjudgmental.

Conveys a caring attitude.

Provide instruction in breathing and relaxation techniques.

Holding the breath and tightening the muscles may influence physiological responses (BP, pulse, and respiration). Tense muscles may interfere with the procedure.

Explain procedures before they are performed, and stay with the client to provide concurrent feedback.

A physical presence is reassuring and can increase cooperation and promote a sense of security.

Have a support person remain with the client, particularly if she is undergoing a second-trimester procedure requiring induction of labor.

The presence of a familiar person can help reduce anxiety and promote relaxation and coping.

NURSING DIAGNOSIS:

Pain/[Discomfort]

May Be Related To:

Aftereffects of procedure/drug effect

Possibly Evidenced By:

Report of discomfort, distraction behaviors, changes in muscle tone, autonomic responses/change in vital signs

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Identify/use methods that provide relief.

Report discomfort is minimized and/or controlled.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Explain to client the nature of discomfort expected.

Knowledge helps the client to cope with reality. Cramping pain during, and for 1 wk after, a first-trimester termination is expected. Clients treated with prostaglandins may experience nausea, vomiting, and diarrhea.

Determine the extent/severity and location of discomfort.

Although some discomfort is expected, severe cramping and abdominal tenderness may indicate complications.

Provide instruction in relaxation and breathing techniques.

May help break the cycle of fear, tension, and pain; provide distraction; and enhance coping.

Collaborative

Administer narcotic/nonnarcotic analgesics, sedatives, and antiemetics, as indicated.

Provide information about the use of prescription or nonprescription analgesics.

These drugs promote relaxation, decrease pain awareness, and control side effects of treatment (drug therapy).

Specific instructions about the use of any drugs increases awareness of safe use and side effects.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:****Injury, risk for maternal**

Surgical procedure/anesthesia

[Not applicable; presence of signs/symptoms establishes an *actual* diagnosis]

Recognize and report signs/symptoms of complications.

Institute appropriate corrective measures.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Monitor and assess blood loss. Count and weigh or estimate peripads.

Monitor vital signs, noting increased pulse rate, severe headache, or flushed face.

Note dyspnea, wheezing, or agitation.

Evaluate level of discomfort.

Instruct client to report symptoms indicating complications (e.g., temperature 100.4° F (40.0°C) or greater, chills, malaise, abdominal pain or tenderness, severe bleeding, heavy flow with clots, foul-smelling and/or greenish vaginal discharge).

Provide information about person to contact in case of emergency.

Bleeding is normally like a heavy menstrual period. Excessive loss (more than 1 large pad per hour for 4 hr) may indicate retained tissue or uterine perforation.

Changes in vital signs are often a late sign of hypovolemic shock from blood loss. If hypertonic saline solution is used in second-trimester procedure and is inadvertently injected into the circulatory system, convulsions and death can occur.

Prostaglandins may cause vasoconstriction or bronchial constriction.

Abdominal pain, tenderness, and severe cramping may indicate retained tissue or uterine perforation.

Clients are in the healthcare facility for a short time. Complications, including bleeding and infection, may be manifested days or weeks after the procedure.

A specific phone number encourages contact; can save time and anxiety.

Stress importance of returning for a follow-up examination.

Collaborative

Assist with/review results of ultrasonography before procedure as indicated.

Determine cervical status before procedure.
Assist as needed with insertion of *Laminaria* tent or prostaglandin (lamicel) gel.

Assist with any additional treatment or procedures necessary to control complications.

(Refer to CP: Labor: Induced/Augmented.)

Follow-up is necessary to assess healing. A repeat pregnancy test is sometimes done after early first-trimester procedures to assure procedure was complete.

Helps in confirming gestational age and the size of products of conception.

Aids in softening cervix; may be inserted 24–48 hr before procedure.

IV therapy may need to be instituted, with or without oxytocics. Additional surgery (D & C or hysterectomy) may be needed to control bleeding.