

The High-Risk Pregnancy

This plan of care provides a general framework for assessing and caring for the client and fetus in a high-risk situation during the prenatal period. Specific high-risk problems that occur in 6% or more of the prenatal population are discussed in the individual plans of care that follow. Less common problems can occur, placing both the client and the fetus in a potentially compromised situation. This plan of care focuses on these less common problems, as well as on general psychosocial considerations for all high-risk clients.

(This plan of care is to be used in conjunction with the Trimesters and other plans of care for specific conditions as appropriate.)

CLIENT ASSESSMENT DATA BASE

Activity/Rest

May be pale, listless, fatigued

Circulation

BP, pulse may be elevated.

Ego Integrity

May express concern about own self-esteem regarding problems of pregnancy.

Pregnancy may not be planned/desired.

Stressors may include financial concerns/lack of health insurance.

Elimination

May practice colonic therapy (diminishes normal colon bacteria)

Food/Fluid

May be malnourished/obese or underweight (weight less than 100 lb/greater than 200 lb).

Dietary choices may not include all food groups (may reflect eating disorder).

History of anemia (differentiate iron deficiency, sickle cell trait/disease, hemorrhage).

Edema may be present in the lower extremities, include both upper/lower extremities, or be generalized.

Neurosensory

May have difficulty with muscle function (i.e., multiple sclerosis, myasthenia gravis, paralysis/spinal cord trauma)

Respiration

Breath sounds: crackles, rhonchi, expiratory wheeze

Safety

History of previous obstetric complications, such as PROM, placenta previa, abruptio placentae, miscarriage, two or more episodes of preterm labor/deliveries, Rh incompatibility, previous birth defects, gestational trophoblastic disease (GTD), hyperemesis gravidarum, one or more pregnancy losses due to premature dilation of the cervix, PIH, or postpartal hemorrhage, infection, or phlebitis.

History of STDs, a virus of the TORCH group, or *Listeria*; repeated urinary tract/vaginal infections; bowel problems; diarrhea; or recent influenza.

History of exposure to teratogenic agents, high-risk occupations.

May have history of intrapartal complications (e.g., hemorrhage, dystocia, PIH, meconium staining, fetal distress).

Inadequate/lack of housing (affects safety as well as general well-being), history of prenatal abuse.

May be jaundiced, screening positive for active hepatitis.
Vaginal discharge may have foul odor.

Sexuality

Fundal height may be inappropriate for gestation.
Perineum may have visible lesions.
May be adolescent (age 17 yr or younger); nullipara, age 35 yr or older; multipara age 40 yr or older; conception less than 3 mo after last delivery or have interval of 8 or more yr between pregnancies.
May have history of large-for-gestational-age infant (macrosomia).
May have had a previous cesarean birth, now opting for attempted vaginal birth after cesarean (AVBAC) or planning a repeat cesarean birth if the primary intervention was based on cephalopelvic disproportion.
Pelvic diameter may be smaller than normal.
Vaginal bleeding or spotting may be present.
History of menstrual problems, such as cramping, or irritable uterus.

Social Interaction

May have history of abusive/unstable relationship
Lack of support systems

Teaching/Learning

History of preexisting medical complications (e.g., diabetes, kidney disease, acquired/congenital cardiac problems, asthma, tuberculosis)
History of substance dependency/abuse

DIAGNOSTIC STUDIES

Ultrasonography (Using Real Time): Assesses gestational age of fetus and presence of multiple gestations; detects fetal abnormalities; locates placenta (and amniotic fluid pockets before amniocentesis, if performed).
Biophysical Profile (BPP) Criteria: Assesses fetal well-being through ultrasound evaluation to measure amniotic fluid index (AFI), FHR/nonstress test (NST) reactivity, fetal breathing movement, body movement (large limbs), and muscle tone (flexion/extension).
Amniocentesis: Determines lecithin to sphingomyelin (L/S) ratio, can detect presence of phosphatidyl glycerol (PG), and measures optical density of fluid for detection of hemolysis in Rh incompatibility or infection in fluid.
Glucose Tolerance Test: Screens for GDM.
Platelet Count: Drop may be associated with PIH and hemolysis, elevated liver enzymes, and low platelet (HELLP) syndrome (hemolysis, elevated liver enzymes, and/or low platelet count).
Serological Studies, VDRL: Screen for hepatitis, human immunodeficiency virus, AIDS, syphilis.
Blood Type, Rh Group, and Screen for Antibodies in Rh-Negative/Du-Negative Client: Identifies incompatibility risks.
Bilirubin, Liver Function Studies (AST, ALT, and LDH levels): Assesses hypertensive liver involvement.
Coagulation Studies (Activated Thromboplastin Time [APPT], Partial Thromboplastin Time [PTT], Prothrombin Time [PT]), Fibrin Split Degradation Products (FSP/FDP): Identifies clotting disorders in presence of hemorrhage.
Urinalysis (or dipstick), Culture/Sensitivity: Determines glucose/protein levels; detects bacteriuria/infecting agent.
Vagina, Cervical, or Rectal Smear: Identifies STDs (e.g., genital herpes, gonorrhea, *Chlamydia*, or *Listeria*).

NURSING PRIORITIES

1. Identify high-risk situations.
2. Minimize risk factors for client and/or fetus.
3. Create ongoing program of education and support.
4. Prevent/minimize deterioration of maternal/fetal status.
5. Counsel client regarding present and/or future pregnancies.

DISCHARGE GOALS

Inpatient care not required, unless complications develop necessitating hospitalization.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Anxiety [specify level]

Situational crises, threat of maternal/fetal death (perceived/actual), interpersonal transmission/contagion

Increased tension, apprehension, feelings of inadequacy, somatic complaints, difficulty sleeping

Verbalize fears and concerns related to complication and/or pregnancy.

Identify healthy ways to deal with anxiety.

Demonstrate problem-solving skills.

Use resources/support systems effectively.

ACTIONS/INTERVENTIONS

Independent

Note level of anxiety and degree of interference with ability to function/make decisions.

Provide emotionally warm and supportive atmosphere; accept client/couple as they present themselves.

Assume an unhurried attitude whenever dealing with the client/family.

Provide 24-hr access to healthcare team.

Review possible sources of anxiety (e.g., prior high-risk pregnancy or premature birth, alterations in family life or role performance, financial concerns related to pregnancy, possible delivery of preterm infant, or employment restrictions).

Assess stress level of client/couple associated with the medical complication, couple's relationship, the relationship of the client/couple to family members, and the availability of a support network.

RATIONAL

Unresolved stress may interfere with accomplishment of the tasks of pregnancy, with normal acceptance of the pregnancy/fetus, and with decisions regarding future pregnancies versus sterilization.

Facilitates development of trusting relationship. Nonjudgmental acceptance promotes sense of trust.

Fear of the unknown and fear of becoming a burden are incompatible with psychological and emotional rest.

Decreases sense of being alone. Anxiety can be reduced when information or help is readily available.

An uncomplicated pregnancy is associated with some anxiety for the client/couple; a medical complication/history of previous poor outcome further intensifies feelings of uncertainty concerning the present pregnancy and may even cause couple to distance themselves emotionally from the fetus. Acknowledgment of the realities of what is happening can provide support.

Poor family relationships and unavailability of support systems may increase stress level. Client may become dependent on other family members, which may affect her self-esteem and increase her feelings of anxiety, as well as add to the family's level of stress.

Encourage client/couple to express feelings of frustration related to therapy regimen and/or lifestyle changes. Explain to client that verbalization is acceptable and important. (Be alert to expressions of concern regarding children at home and “wanting to deliver and get it over with.”)

Observe for signs of emotional changes, imbalance, or conflict with family/significant other(s).

Assess physiological response to anxiety (e.g., BP, pulse).

Provide individually appropriate information regarding interventions or treatments (inpatient or outpatient basis) and the potential impact of condition on client and fetus.

Reinforce positive aspects of maternal/fetal condition, if present, such as fetal growth and activity.

Collaborative

Coordinate team conference including client/couple. Create ongoing plan of care.

Refer to community support group, such as the MS Society, American Diabetes or Lung Associations, or to couples who have successfully completed a high-risk pregnancy.

Refer to other resources/counseling, as indicated. (Refer to NDs: Family Processes, risk for altered; Family Coping: potential for growth).

Client/couple needs frequent opportunities to vent anger/frustration about changes in family life in order to minimize anxiety levels. Allowing such expression reassures client that these feelings are normal and expressing them is helpful.

Anxiety/frustration may interfere with making realistic decisions.

Provides opportunity for early intervention.

Anxiety is “contagious” and may be transmitted between client on the one hand, and family and staff members, on the other.

Anxiety/stress may be accompanied by the release of catecholamines, creating physical responses that affect the client’s sense of well-being, thus increasing anxiety.

Helps to reduce anxiety associated with the unknown. May enhance cooperation with treatment regimen, promoting optimal pregnancy outcome.

Increases confidence and hope for client and significant other(s).

Promotes continuity of care and team approach to situation. If hospitalization is necessary, stress levels tend to increase further after 2 wk and remain elevated for the remainder of the hospitalization.

Decreases sense of being alone and can help couple develop a positive outlook on pregnancy.

May need help with child care and housekeeping. Counseling or therapy may be necessary to help client/couple verbalize more freely and examine unmanageable anxiety.

NURSING DIAGNOSIS:

Knowledge deficit [Learning Need], regarding high-risk situation/preterm labor

May Be Related To:

Lack of exposure to and/or misinterpretation of information, unfamiliarity with individual risks and own role in risk prevention/management

Possibly Evidenced By:

Request for information, statement of concerns or misconceptions, inaccurate follow-through of instructions

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Verbalize awareness of condition(s) placing her at risk.

Identify signs/symptoms of preterm labor.

List possible preventive measures.

Participate in achieving the best possible pregnancy outcome.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Provide information related to specific high-risk situation, including clear, simple explanations of pathophysiological changes and maternal and fetal implications.

Increases understanding of the impact of pregnancy on the disease process. Client's/ significant other(s)' level of knowledge of, and involvement in, preventive measures appears to have a direct impact on the outcome of an at-risk pregnancy.

Provide appropriate information related to screening and testing methods and procedures.

Understanding of tests can reduce anxiety and may increase client cooperation.

Emphasize the normalcy of pregnancy.

Avoids/limits perception of "sick role" and provides support to client/couple to deal with their specific situation.

Assist client to identify individually appropriate adaptations/self-care techniques: maintaining fluid volume (2–3 L/day), voiding every 2 hr during the day, scheduling rest periods 2–3 times a day using lateral position, avoiding overexertion or heavy lifting, and maintaining contact with family/daily life when bedrest is required.

Preventive problem solving promotes participation in own care and enhances self-confidence, sense of control, and client/couple satisfaction. Note: Bedrest may result in generalized weakness, raising safety concerns when client is out of bed.

Identify danger signals requiring immediate notification of healthcare provider (e.g., PROM, preterm labor, vaginal bleeding).

Recognizing risk situations encourages prompt evaluation/intervention, which may prevent or limit untoward outcomes.

Define labor and review possible symptoms of preterm labor: painless or painful uterine contractions or rhythmic pressure, occurring 10 or fewer min apart; contractions lasting 30 sec or longer for 1 hr (unrelieved by rest, drinking fluids, or emptying bladder); cramps resembling those of menstruation; abdominal cramping with or without diarrhea; and pressure or aching of the low back and/or vulva unrelieved by resting on left side (though may sometimes be relieved by sacral massage).

May help clarify misconceptions regarding "false labor" and aid client in distinguishing between preterm labor and Braxton Hicks contractions. Symptoms of preterm labor may be overlooked by confusing them with normal "aches and pains" of pregnancy.

Describe potential implications of premature birth.

Increases understanding of need for prevention and motivation to follow therapeutic regimen.

Encourage client to assess uterine tone/contractions for 1 hr, once or twice a day.

Although uterine contractions occur occasionally, cervical dilation can occur with contractions every 10 min or less for a period of 1 hr.

Demonstrate technique and specific equipment used when FHR monitoring is done in the home setting.

Provides opportunity for more detailed information regarding fetal well-being in a less stressful environment. Enhances sense of active involvement.

Stress importance of reporting increased or altered vaginal discharge.

Discuss implications of unknown progression of degenerative neurological conditions for client/infant.

Review significance of symptoms of respiratory difficulty, fatigue, and upper eyelid drooping in client with myasthenia gravis. Discuss implications for care of self and infant after birth.

Discuss impact of rheumatoid arthritis on pregnancy/postpartal period, as well as need to avoid nonsteroidal anti-inflammatory drugs such as aspirin.

May reflect cervical changes; indicates need to screen for vaginal infections, which may precipitate preterm labor or may indicate PROM.

Conditions such as multiple sclerosis may occasionally complicate pregnancy or develop afterward; however, exacerbations or remissions seem unrelated to pregnancy. If severely affected, client may elect to interrupt pregnancy or undergo sterilization. Note: Decreased sensation may alter client's ability to sense uterine contractions/presence of labor.

Peak prevalence of this motor endplate disorder occurs at age 25 yr, and pregnancy may increase severity of symptoms. Myasthenia gravis is not an indication for therapeutic abortion, but adjustments may be required to care for infant and self.

Severity of symptoms often subside during pregnancy, yet severe exacerbations may occur 1 mo after delivery, making infant care difficult. Aspirin is contraindicated owing to its effect on maternal/fetal platelets, coagulation, and corresponding anemia related to blood loss. Note: Extra rest is important to protect weight-bearing joints.

NURSING DIAGNOSIS:

May Be Related To:

Possibly Evidenced By:

**DESIRED OUTCOMES/EVALUATION
CRITERIA—FAMILY WILL:**

Family Coping: potential for growth

Needs sufficiently gratified and adaptive tasks effectively addressed to enable goals of self-actualization to surface

Attempts to describe growth impact of this crisis on own values, priorities, and goals; moving in direction of health-promoting and enriching lifestyle that supports and monitors maturational process; generally chooses experiences that optimize wellness

Verbalize fears/perceived disruptions in family life caused by high-risk pregnancy.

Seek assistance/counseling, as needed.

ACTIONS/INTERVENTIONS

Independent

Assess perceived impact of complication on client and family members. Encourage verbalization of concerns.

Provide primary caregiver for client and encourage thorough documentation.

RATIONALE

Family stress often occurs in an uncomplicated pregnancy, and it is amplified in a high-risk pregnancy, where concerns focus on the health of both the client and fetus. Family is strengthened if all members have a chance to express fears openly and work cooperatively.

Ensures continuity of care, enhances ongoing identification and prevention of additional problems, and ensures appropriate follow-up to assist during postpregnancy readjustment.

Help client/couple plan restructuring of roles/ activities necessitated by complication of pregnancy.

Include partner/siblings in prenatal office visits or hospital visits if client is hospitalized. Arrange place for family to stay overnight.

Listen for expressions of helplessness and concern about how current situation is affecting the family and home. Problem-solve solutions.

Focus on pregnancy milestones, “countdown to birth.”

Collaborative

Refer to community service agencies (e.g., visiting nurse, social service); or resources, such as Sidelines.

Refer for counseling if family does not sustain positive coping and growth. (Refer to ND: Family Processes, risk for altered.)

Education, support, and assistance in maintenance of family integrity help foster growth of its individual members and reduce stress that the client may feel from her dependent role.

Helps family members to view the outcome of the pregnancy as a cooperative effort. Proper management of stress at this time may promote growth within the family and individual members.

Medical problems necessitating special therapy/restrictions at home or hospitalization significantly disrupt normal routines and cause stress and guilt feelings in the client, partner, and/or siblings. Creative solutions enhance self-esteem, may increase participation/cooperation with medical regimen, and can promote family involvement.

Promotes sense of hope that modifications/ restrictions serve a worthwhile purpose. Helps client/significant others look forward instead of dwelling only on the concerns of the present.

Community supports may be needed for ongoing assessment of medical problem, family status, coping behaviors, and financial stressors. Sidelines is a national telephone support group for pregnant women on bedrest.

May be necessary to promote growth and to prevent family disintegration.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Nutrition: altered, risk for less/more than body requirements

Extremes of weight (less than 100 lb/greater than 200 lb), inability to ingest/digest food, excessive/ inappropriate intake, limited financial resources

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

Gain 24–28 lb during the pregnancy.

Follow a well-balanced diet.

Be free of ketones in urine.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Ascertain current/past dietary patterns and practices.

Ascertaining the nutritional state before conception is critical to ensuring proper organ development, especially brain tissue, in the early weeks of pregnancy.

Weigh client. Compare current weight with pregravid weight. Have client record weight between visits.

Underweight clients are at risk for anemia, inadequate protein/calorie intake, vitamin/mineral deficiencies, and PIH. Overweight women are at risk for possible changes in the cardiovascular system that create risks for development of PIH, GDM, and hyperinsulinemia of the fetus, resulting in macrosomia. New research indicates increased risk of fetal distress and cesarean delivery. Sudden weight gain of 2+ lb in a week may indicate PIH; a weight loss of 3 lb or more near term suggests postmaturity.

Provide information about risks of weight reduction during pregnancy and about nourishment needs of client and fetus.

Prenatal calorie restriction and resultant weight loss may result in nutrient deficiency or ketonemia, with negative effects on fetal central nervous system (CNS) and possible IUGR.

Test urine for presence of ketones.

Indicates inadequate glucose utilization and breakdown of fats for metabolic processes.

Develop plan with client that provides necessary nutrients, including adequate fluid intake. Recommend at least 2 quarts of noncaffeinated fluid per day.

Prevents malnutrition and dehydration, which appear to compromise optimal uterine and placental functioning and increase uterine irritability, which could potentiate premature labor.

Discuss importance of staying on low-phenylalanine diet for the woman with phenylketonuria (PKU).

This client should have begun the diet before becoming pregnant and continue the diet throughout the pregnancy to prevent elevated phenylpyruvic acid levels and reduce the risk of mental retardation, microcephaly, congenital heart defects, and growth retardation/restriction (IUGR).

Encourage close monitoring of blood glucose levels, as appropriate.

Type I or insulin-dependent diabetes mellitus (IDDM) clients generally need to check blood glucose levels 4–12 times/day because insulin needs may increase 2 to 3 times above pregravid baseline.

(Refer to CPs: First Trimester, Diabetes Mellitus: Prepregnancy/Gestational; ND: Nutrition: altered, risk for less than body requirements.)

NURSING DIAGNOSIS:

Injury, risk for fetal

Risk Factors May Include:

Maternal health problems, substance use/abuse, exposure to teratogens/infectious agents

Possibly Evidenced By:

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

DESIRED OUTCOMES/EVALUATION

Verbalize understanding of individual risk factors.

CRITERIA—CLIENT WILL:

Participate in screening procedures as indicated.

Display fetal growth within normal limits (WNL).

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Note maternal conditions that affect fetal circulation, such as PIH, diabetes, cardiac or kidney disease, anemia, Rh incompatibility, or hemorrhage, as well as maternal age. (Refer to appropriate plans of care.) Assess for excessive nausea/vomiting.

Any factor that interferes with or reduces maternal circulation/oxygenation has a similar impact on placental/fetal oxygen levels. The fetus who is unable to obtain sufficient oxygen for metabolic needs from maternal circulation resorts to anaerobic metabolism, which produces lactic acid, leading to an acidotic state. Maternal age above 35 is associated with some increase in risk of abruptio placentae, preterm delivery/stillbirths, fetal chromosomal abnormalities, and IUGR. The most common maternal complications in this age group are PIH and gestational diabetes.

Ascertain use of thalidomide before conception.

Exposes developing fetus to acidotic state and malnutrition and may contribute to IUGR and poor brain growth. Development of hyperemesis gravidarum may require hospitalization.

Determine use/abuse of substances such as tobacco, alcohol, and other drugs. Provide information about negative effects on fetal growth.

Clients with HIV/AIDS may have used this drug to prevent or reverse weight loss; however, it has potential for severe birth defects.

Screen for occurrence of abuse during pregnancy.

Depending on the extent of use, these substances may result in varying degrees of involvement ranging from an identifiable syndrome such as fetal alcohol syndrome to less specific developmental disorders/delays.

Note estimated date of birth (EDB).

Prenatal abuse is a significant risk factor for low birth weight, preterm delivery, and other poor outcomes.

Assist in screening for and identifying genetic/chromosomal disorders. (Refer to CP: Genetic Counseling.)

Placental function is characterized by intense metabolic activity and oxygen consumption, which increases until term and then begins to fall. A post-term placenta becomes calcified and degenerates, thereby reducing surface available for oxygen and nutrient transfer and increasing perinatal mortality.

Discuss potential negative effects of identified condition (e.g., PKU) on fetus, and review options available to client. (Refer to ND: Nutrition: altered, less/more than body requirements and CP: Genetic Counseling.)

Disorders such as PKU or sickle cell anemia necessitate special treatment to prevent negative effects on fetal growth.

Intrauterine or postnatal growth retardation/restriction, malformation, or mental retardation may occur in PKU if pregnant woman does not resume diet low in phenylalanine for the duration of the pregnancy.

Assess FHR, noting rate and regularity. Have client monitor fetal movement daily as indicated. Note presence of maternal conditions that may also impact FHR (e.g., maternal hyperthyroidism or Graves' disease).

Assess or screen for preterm uterine contractions, which may or may not be accompanied by cervical dilatation. (Refer to CP: Preterm Labor/Prevention of Delivery.)

Monitor FHR during sickle cell crisis.

Collaborative

Monitor maternal laboratory studies:

Serology tests;

Blood type/group;

Serum human placental lactogen (HPL), and serum/urinary estriol levels. (Note: Recent studies suggest use of BPP/NST rather than estriol/HPL levels);

MSAFP₃ levels at 14–22 weeks' gestation and amniocentesis, if levels are abnormal.

Administer RhIgG to client at 28 weeks' gestation, then again 72 hr postpartum, if indicated.

Prepare client for/review serial testing:

Ultrasonography (Refer to ND: Gas Exchange, risk for impaired maternal and CPs: Diabetes Mellitus: Prepregnancy/Gestational; Pregnancy-Induced Hypertension; Cardiac Conditions);

Tachycardia in a term infant may indicate a compensatory mechanism to reduced oxygen levels and/or presence of sepsis. A reduction in fetal activity occurs before bradycardia. Although fetal thyrotoxicosis is rare, IUGR or tachycardia may result if maternal condition is untreated. Note: Fetal hypothyroidism may result from maternal low-dose antithyroid drug therapy; higher doses may produce a goiter or mental retardation.

Occurs in 6%–7% of all pregnancies and may result in delivery of a preterm infant if tocolytic management is not successful in reducing uterine contractility and irritability.

Maternal acidosis/hypoxia, especially in third trimester, can result in fetal CNS disorders. Repeat crises predispose the client and fetus to increased mortality and morbidity rates.

Assess for presence of TORCH group of viruses and active/carrier state of hepatitis. (Refer to CP: Prenatal Infection.)

Identifies fetus at risk for isoimmunization.

Alterations in placental secretion of HPL/estriol may indicate fetal/placental problems. Low levels occur in toxemia, IUGR, and postmaturity. Elevated levels accompany Rh sensitization, diabetes, maternal sickle cell anemia, and liver diseases.

Triple screen measures alpha-fetoprotein, unconjugated estriol, and human chorionic gonadotropin levels. With a neural tube defect (NTD), most commonly spina bifida and anencephaly, AFP (a protein produced by the yolk sac and fetal liver) is present in maternal serum at a level 8 times higher than normal at 15 weeks' gestation. The AFP level then decreases until term. Also useful in detecting other problems, such as ventral wall defects, Down syndrome, and trisomy 18.

In Rh-negative clients with Rh-positive partners, RhIgG helps reduce incidence of maternal isoimmunization in nonsensitized mothers and helps prevent erythroblastosis fetalis and fetal red blood cell (RBC) hemolysis.

Monitors clients at risk for reduced/inadequate placental perfusion, such as adolescents, clients older than 35 yr, clients with diabetes, PIH, cardiac/kidney disease, anemia, or respiratory disorders. Inadequate placental perfusion with reduced transfer of oxygen/nutrients may result in fetal IUGR.

NST;	<p>A reactive NST indicates integrity of placental circulation and fetal CNS as evidenced by two or more FHR accelerations of at least 15 bpm lasting 15 sec or longer in a 20-min period during which the baseline rate is WNL and variability is average. Chronic intrauterine hypoxia caused by vascular changes or postmaturity results in reduced fetal activity, tachycardia, reduced beat-to-beat variability, possibly nonreactive stress test, positive CST, falling estriol levels, and decreased fetal muscle tone and breathing movements. Note: A positive CST with late decelerations indicates a high-risk client/fetus with possible reduced uteroplacental reserves; a negative CST indicates adequate fetal oxygen reserve/placental functioning.</p>
BPP and contraction stress test (CST) (if result of NST nonreactive or unequivocal).	
Provide supplemental oxygen as appropriate.	<p>Increases the oxygen available for fetal uptake, especially in presence of severe anemias or sickle cell crisis, or when maternal/fetal circulation is compromised.</p>
Provide information and assist with procedures as indicated, for example:	
Aminocentesis;	<p>Aminocentesis may be performed for genetic purposes or to assess fetal lung maturity. Spectrophotometric analysis of the fluid may be done to detect bilirubin after 26 weeks' gestation. If serum titer is greater than 1:16, sensitization occurs when maternal/fetal cells mix, creating an antigen-antibody response with hemolysis of fetal RBCs and release of bilirubin. Kleihauer-Betke test detects presence of fetal blood in maternal system. RhIgG may prevent procedural isoimmunization. Most common complication is preterm labor requiring ongoing monitoring by client following the procedure. Helps detect negative fetal/uterine response to procedure. Lateral position increases uteroplacental perfusion.</p>
Administer RhIgG after amniocentesis (based on results from Kleihauer-Betke test);	
Observe external fetal monitor for 20–30 min after amniocentesis, position client on side;	<p>If excess fetal RBC hemolysis occurs, transfusion into fetal peritoneal cavity with RhO-negative blood replaces hemolyzed RBCs when fetus is determined at risk of dying before 32 weeks' gestation.</p>
Intrauterine fetal exchange transfusion and repeat transfusion every 2 wk as indicated by titers (Kleihauer-Betke test) followed by administration of RhIgG;	<p>Although it is not widely used, fetoscopy permits fetal blood/skin sampling and direct visualization of the fetus with identification of genetic or developmental problems such as sickle cell anemia, hemophilia, thalassemia major; immunologic problems, Rh isoimmunization; and NTD.</p>
Fetoscopy.	
Determine fetal maturity when early delivery is anticipated, using results from amniotic fluid analysis for surfactant PG, creatinine, bilirubin, and cytological analysis.	<p>Fetal lung maturity is indicated by an L/S ratio of 2:1 or greater, except in an infant of a diabetic mother. Presence of PG and creatinine levels of 2.0 mg/100 ml reflect kidney maturity. Cornified cells are present at 36 weeks' gestation. Bilirubin levels of 0.025 mg/dl in mothers having no Rh isoimmunization indicate fetal maturity.</p>

Prepare for, and assist with, termination of pregnancy by induction or cesarean delivery as indicated.

Pregnancy may be terminated if desired for such conditions as toxoplasmosis occurring before 20 weeks' gestation, rubella during the first trimester, or elevated AFP levels indicating NTD. In event of post-term placental calcification or deterioration of maternal condition, labor may be induced.

NURSING DIAGNOSIS:**Injury, risk for maternal****Risk Factors May Include:**

Preexisting medical conditions, complications of pregnancy

Possibly Evidenced By:

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

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Identify signs/symptoms requiring medical evaluation/intervention.

Verbalize understanding of individual risk factors.

Be free of maternal injury.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Review obstetric/medical history. Note maternal age.

Helps identify individual risk factors. Women over age 35 have an increased occurrence of PIH, gestational diabetes, spontaneous abortions, and bleeding problems.

Screen for abuse during pregnancy.

Prenatal abuse is correlated with a low maternal weight gain, infections, anemia, and delay in seeking prenatal care until the third trimester.

Discuss the option of AVBAC in client with incision into the lower uterine segment and potential risks associated with previous classical incision into uterus.

Potential for uterine rupture in subsequent pregnancies exists when incision is a classical (vertical) incision or gestational age is not accurately determined, resulting in overdistension and stimulating onset of labor.

Refer client/couple for AVBAC or cesarean classes, as appropriate.

Provides information/opportunity for asking questions to prepare client for delivery.

Discuss unpredictable effect of pregnancy on epileptic/seizure disorders. Review information regarding medical control with diazepam (Valium), chlordiazepoxide hydrochloride (Librium), and phenytoin (Dilantin).

Pregnancy may cause an increase in seizure activity, especially if complications occur. Note: Dilantin has been associated with cleft lip/palate in the newborn. Other anticonvulsants may impair clotting, requiring prophylactic use of vitamin K during the last month of pregnancy to prevent neonatal hemorrhage.

Assess renal/cardiac involvement in client with systemic lupus erythematosus (SLE). Provide information about the need to continue with corticosteroid intake throughout pregnancy.

Discuss safety concerns related to presence of spinal cord injury/paralysis.

Monitor for temperature elevation. Note diaphoresis, tachycardia, fine tremors, weight loss, and altered bowel function.

Investigate reports of excessive nausea/vomiting in conjunction with elevated BP, pathological edema, and proteinuria.

Collaborative

Assist with ultrasonography; note absence of fetal heart outline or FHTs. Monitor elevation of HCG titers.

Assist in uterine evacuation by induced abortion, dilation and curettage (D & C), or hysterectomy, as indicated.

Stress need to follow up HCG titers for at least 1 yr.

Review thyroid profile studies and serum thyroxine values.

Administer propylthiouracil (PTU) or methimazole as indicated.

Increased rates of spontaneous abortion, cardiac problems, preterm labor, stillbirth, PIH, and even maternal death occur in the client with SLE-related kidney involvement.

For clients at risk for autonomic dysreflexia, episode may be relieved or prevented by appropriate emptying of the bladder. Other concerns, such as altered mobility/transfer and increased attention to skin care needs, can generally be managed with preventive planning.

May indicate onset of hyperthyroidism/thyrotoxicosis, which in addition to deleterious fetal effects (increased mortality and LBW infants), may result in pernicious vomiting and cardiac stress.

Hyperemesis gravidarum and PIH before 24 weeks' gestation may develop in association with hydatidiform mole.

Diagnostic for hydatidiform mole (molar pregnancy), which is most likely to occur in older women or women treated with clomiphene citrate (Clomid). Sequelae of choriocarcinoma may develop if HCG titers remain high after evacuation.

Surgery ensures complete removal of all placental fragments. In the presence of excessive bleeding, or in older clients who have increased risk of malignant sequelae, hysterectomy may be the treatment of choice.

Pregnancy should be delayed for 1 full year after negative HCG titers are achieved. Chemotherapy is recommended if titers rise/remain high and D & C reveals malignant cells.

Helpful in confirming hypothyroid or hyperthyroid state and identifying treatment needs. Note: Untreated hypothyroidism markedly increases the risk of fetal loss, congenital goiter, and true cretinism; untreated hyperthyroidism potentiates risk of abortion or fetal demise.

Helps reduce effects of Graves' disease and thyrotoxicosis by interfering with synthesis of thyroid hormones. Radioisotope treatment is contraindicated in pregnancy.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

Self Esteem, risk for situational low

Perceived failure at a life event

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

**DESIRED OUTCOMES/EVALUATION
CRITERIA—CLIENT/COUPLE WILL:**

Verbalize thoughts/feelings about situation.

Express positive self-appraisal.

Seek appropriate referral as needed.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Encourage verbalization of feelings. Assess perception of self in nonpregnant state and alteration in perception with pregnancy.

Helps detect problems and determine their severity. Because pregnancy is thought to be a normal physiological process, a high-risk situation can lead to alterations in self-concept, lowered self-esteem, and ego disintegration, especially if one or both members of the couple associate child rearing with success as a woman or man.

Note issues of lack of control.

Client is often frustrated by a loss of control over her body as well as the pregnancy in general, with a sense that all control is in the hands of healthcare providers.

Facilitate positive adaptation to altered self-concept through Active Listening, acceptance, and problem solving.

Helps in successful accomplishment of the psychological tasks of pregnancy, although the high-risk couple may remain ambivalent as a self-protective mechanism against possible loss of the pregnancy/fetal death.

Encourage involvement in decisions about care when possible.

Enhances sense of control and increased self-esteem. Note: Client is often required to undergo many procedures with few—if any—alternatives offered. Pressure may be perceived as implication that the procedure may be the only chance of delivering a viable infant; or if medical option is refused, insurance payor may deny benefits for costs associated with the pregnancy.

Promote attendance at classes/support groups, identify computer-based resources, e.g., E-mail, on-line support groups, as appropriate.

Provides information for client/couple and reassurance that they are not alone.

Collaborative

Refer for individual/group counseling, if indicated.

May be necessary for positive ego integration.

NURSING DIAGNOSIS:

Fluid Volume risk for deficit

Risk Factors May Include:

Inability to ingest and retain fluids

Possibly Evidenced By:

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

**DESIRED OUTCOMES/EVALUATION
CRITERIA—CLIENT/COUPLE WILL:**

Maintain adequate circulating volume as evidenced by vital signs WNL, urine output greater than 30 ml/hr, moist mucous membranes, and good skin turgor.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine presence/frequency of excessive or persistent nausea and vomiting/retching.

Pernicious vomiting (hyperemesis gravidarum) results in dehydration, hypovolemia, and metabolic changes, exposing the developing fetus to acidotic state and malnutrition, which may contribute to IUGR and poor brain growth or possibly death.

Note client reports of nervousness or heat intolerance and presence of fine tremors, temperature elevation, excessive diaphoresis, or tachycardia.

Signs suggestive of hyperthyroid state may cause excessive vomiting.

Monitor BP and pulse.

Dehydration/hypovolemia may cause hypotension or tachycardia.

Recommend pacing of activities, adequate sleep, and bedrest, as appropriate.

Conserves energy; allows closer monitoring of physical status.

Record intake/output; measure urine specific gravity.

Provides information regarding hydration and effectiveness of fluid replacement.

Encourage frequent oral care.

Dehydration and acid emesis may cause drying and irritation of mucous membranes.

Note signs of mucosal bleeding or hemorrhage. Recommend use of soft toothbrush, alcohol-free mouthwash, and ingestion of soft foods.

Severe vitamin deficiencies and hypothermia may alter coagulating ability. Preventing trauma to mucous membranes reduces likelihood of bleeding.

Review need for and/or use of antithyroid drugs, such as propylthiouracil (PTU) or methimazole (Tapazole).

Interferes with synthesis of thyroid hormone and helps overcome intractable vomiting (hyperemesis) caused by hyperthyroid state. However, fetal consequences may include hypothyroidism, goiter, or mental retardation.

Collaborative

Monitor laboratory studies as indicated:

Electrolytes;

Electrolyte/acid-base imbalances are common and may be life-threatening.

Hct;

Elevated in dehydration. May be useful in assessing fluid needs.

BUN;

Hypovolemia reduces renal perfusion and function, elevating BUN.

Thyroid studies and serum thyroxine levels.

Elevated in client with hyperthyroidism/Graves' disease.

Administer prochlorperazine (Compazine) or hydroxyzine (Vistaril) as indicated, or monitor low-dose promethazine (Phenergan) infusion.

Provides sedative action and prevents vomiting, but may have teratogenic effects.

Administer parenteral fluids, electrolytes, glucose, or supplemental vitamins, as indicated.

Provide diet as tolerated (may be nothing by mouth [NPO] for 24–48 hr) starting with small/dry feedings followed by clear liquids and progressing to low-fat, soft, then regular foods.

Refer to psychological counseling if no improvement occurs.

Prepare for therapeutic abortion if warranted by patient's condition.

Helps reverse or prevent possible hypokalemia, severe protein/vitamin deficiencies, or acidosis, which may negatively affect maternal/fetal well-being.

Allows the gastrointestinal tract an initial period of rest. Gradually increasing oral feedings may improve food tolerance.

There may be a psychological component to the problem of vomiting.

Early recognition and treatment should prevent such a severe situation from developing, but it may be indicated when mother's life is threatened, as evidenced by jaundice, prolonged fever greater than 101°F (38.3°C), tachycardia, retinal hemorrhage, and delirium.

NURSING DIAGNOSIS:**Risk Factors May Include:****Possibly Evidenced By:****DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:**

Gas Exchange, risk for impaired maternal

Altered blood flow, alveolar-capillary changes, reduced oxygen-carrying capacity of blood

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

Verbalize understanding of individual risk factors.

Identify and use interventions to reduce risks.

Display BP, pulse, respiratory rate, and hemoglobin (Hb) and hematocrit (Hct) within normal limits.

Refer to discussion of circulatory considerations in CPs: Pregnancy-Induced Hypertension; Cardiac Conditions.

ACTIONS/INTERVENTIONS

RATIONALE**Independent**

Assess for respiratory disorders that may interfere with lung function, such as asthma or tuberculosis. Note maternal respiratory rate or effort and adventitious lung sounds.

Note conditions potentiating vascular changes/reduced placental circulation (e.g., diabetes, PIH, cardiac problems) or those that alter oxygen-carrying capacity (e.g., anemias, hemorrhage). (Refer to specific plans of care as needed).

Any condition, either preexisting or developing during the pregnancy, that reduces or interferes with oxygen-carrying capacity impairs normal gas exchange. Such conditions may be a result of problems related to respiration, circulation, or cellular components.

Extent of maternal vascular involvement and reduction of oxygen-carrying capacity have a direct influence on uteroplacental circulation and gas exchange. IUGR and birth of an LBW or small-for-gestational-age infant are associated with maternal vascular changes.

Monitor BP and pulse.

Promote bed/chair rest. Position in upright or semi-Fowler's position when respiratory effort is compromised; otherwise, encourage client to assume lateral position.

Monitor maternal kidney function, noting overall intake/output, and measure urine-specific gravity, as indicated.

Encourage increased fluid intake as appropriate/tolerated.

Review dietary sources of vitamin C, iron, and protein. Discuss individual need for sufficient calories. Identify substances that foster iron absorption (acid medium, vitamin C) and those that reduce absorption (alkaline medium, milk).

Reduce stressors precipitating allergic/asthmatic response in susceptible client.

Encourage maternal avoidance of potential stressors that may precipitate sickle cell crisis (e.g., hypoxia, dehydration, acidosis, exposure to cold).

Collaborative

Monitor maternal laboratory studies as indicated:

Hb/Hct using electrophoresis;

BUN, creatinine clearance, 24-hr protein, and uric acid levels;

Arterial blood gases (ABGs).

Administer medications, as indicated:

Theophylline;

Iron dextran (Imferon);

Isoniazid/ethambutol/rifampin.

Elevated BP may indicate PIH; reduced BP and increased pulse may accompany hemorrhage.

Reduces respiratory effort and increases oxygen consumption as diaphragm falls, increasing vertical chest diameter. Side-lying position increases renal/placental perfusion; either position is effective in preventing supine hypotensive syndrome.

Kidney function may deteriorate during pregnancy, negatively affecting cardiovascular function, elevating BP, and reducing placental circulation.

Prevents dehydration, enhances organ perfusion/function, and liquefies respiratory secretions to facilitate expectoration.

Inadequate nutrition results in iron deficiency anemia and may lead to problems of oxygen transport.

Decreases incidence of attacks. Impact of asthma on pregnancy is questionable, although it may be associated with increased incidence of abortion and preterm labor.

Maternal acidosis/hypoxia, especially in third trimester, can result in fetal CNS disorders. Repeat crises predispose the client/fetus to increased rates of mortality/morbidity.

Any reduction in Hb levels or circulating blood volume reduces oxygen available for maternal tissues. Treatment depends on the cause of the anemia as diagnosed by electrophoresis. Evaluates adequacy of renal function.

Determines oxygenation and therapy needs.

Assists in bronchial dilation but may be associated with side effects of tachycardia in client/fetus.

Parenteral administration may be necessary in presence of severe iron deficiency anemia to increase maternal oxygen-carrying capacity. Active tuberculosis requires treatment. Isoniazid crosses the placenta but does not appear to have teratogenic effects. Rifampin also crosses the placenta, but studies of fetal effects are still in progress. Streptomycin is avoided owing to association with vestibular/auditory defects. Note:

Provide supplemental oxygen.

Assist with prophylactic exchange transfusion or crisis/anemia transfusion as indicated.

Isoniazid therapy requires supplementation of pyridoxine (vitamin B₆).

May be indicated in presence of severe anemias or during sickle cell crisis.

Helps maintain maternal hemoglobin S (HbS, abnormal sickle cell) level at less than 50%–60% of total Hb, or Hct at 30%, to improve oxygen-carrying capacity.

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

Presence of circulatory/respiratory problems, uterine irritability

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

Report an awareness of level of tolerance of activity.

Plan necessary alterations in lifestyle/daily activities.

Be free of excessive fatigue or uterine irritability/sustained contractions.

ACTIONS/INTERVENTIONS**RATIONALE**

Independent

Encourage client to pace activities and allow sufficient rest.

Review home/employment situation, noting activity levels and individual responses.

Discuss activity prescription/limitations.

Encourage adequate rest and use of lateral position.

Instruct client to avoid heavy lifting, strenuous activity/housework, sports, and motor trips longer than 1–2 hr. (Note: Client with cardiac condition may have more severe restrictions.)

Instruct client to modify or eliminate any type of sexual activity in the presence of symptoms of preterm labor, cervical changes, or bleeding.

Recommend avoiding travel and altitude changes in the third trimester.

Conserves energy and avoids overexertion to minimize fatigue/uterine irritability.

Promotes collaborative problem solving and may enhance participation in modifications of activity.

Therapeutic regimen may dictate specific modifications depending on symptoms and previous history.

Increases uterine blood flow and may decrease uterine irritability/activity.

Previously tolerated activity may not be indicated for women at risk. Aerobic exercise/abdominal muscle strain may decrease uterine blood flow and increase uterine irritability.

Sexual activity, including orgasms and breast stimulation, appears to increase uterine irritability, owing to release of oxytocin.

Motion of travel, prolonged sitting position, and decreased oxygen appear to increase uterine irritability.

Stress importance of quiet diversional activities.

Prevents boredom and enhances cooperation with activity restrictions.

Collaborative

Encourage modified/complete bedrest as indicated.

Activity level may need modification, depending on symptoms of uterine activity, cervical changes, or bleeding. Note: Generalized weakness may develop as a result of prescribed total bedrest with concerns for self-care and independence in the postpartal period.

NURSING DIAGNOSIS:

Coping, Individual/Family, ineffective: risk for compromised

Risk Factors May Include:

Situational crisis, personal vulnerability, inadequate support systems

Possibly Evidenced By:

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

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT/FAMILY WILL:

Identify ineffective coping behaviors and consequences.

Verbalize awareness of own strengths/coping abilities.

Demonstrate coping by discussing fears and dealing positively with the situation.

Seek help appropriately.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Assess past and present coping strategies and emotional response to event/diagnosis.

In coping with a high-risk pregnancy, the client/couple/family often uses denial, then guilt, blame, or feelings of ambivalence, as emotional protection from possible loss of the pregnancy and fetus/newborn.

Evaluate client's/couple's support systems, including ability to comfort one another. Note negative coping, and discuss consequences.

Often, as a protective mechanism, the client and her partner do not form positive emotional attachment ("give of themselves") to the fetus. Lack of adequate support systems and failure to achieve the normal developmental tasks of pregnancy may result in continuation of high-risk situation into the childrearing phase and may create potential problems associated with physical or emotional child abuse and high-risk parenting.

Discuss normalcy of feelings; encourage couple to verbalize (separately and together) their feelings and concerns.

Note client reports of increasing fatigue and inability to manage daily household activities.

Encourage family restructure daily activities to meet client's needs without negating their own needs.

Obtain/review history of increasing severity of symptoms, especially if hospitalization is necessary.

Collaborative

Identify available community support groups.

Refer family for homemaker/child care and financial assistance as necessary.

Refer for counseling as appropriate.

Helps assure client/couple that feelings are appropriate in high-risk situation; promotes open lines of communication. Note: One member of the couple may be reluctant to discuss fears openly in front of partner; may require additional support to facilitate interaction with one another.

Lack of family's assistance may indicate a need for help to resolve situation. Client may be reluctant to relinquish responsibilities and/or significant other(s) may be preoccupied with own emotional conflicts/personal suffering and express lack of understanding/knowledge about how to be helpful.

Family may need assistance in recognition of the importance of time planning to meet such needs as increased rest during pregnancy. However, family needs to work as a group to problem-solve solutions that meet individual needs and prevent negative feelings and "sabotage behaviors."

Problems may require a reduction in activity level and/or hospitalization, necessitating changes in family life.

Discussion of situation with others who share the same problem can be helpful and can enhance problem solving.

Additional outside assistance with everyday activities, sibling care, and/or financial help may be required for client to cope positively with daily needs/therapy regimen.

May be needed in presence of negative coping to assure attachment to pregnancy/fetus/newborn. Helps to resolve concerns and/or develop effective coping skills; may prevent high-risk parenting.

NURSING DIAGNOSIS:

Risk Factors May Include:

Possibly Evidenced By:

**DESIRED OUTCOMES/EVALUATION
CRITERIA—FAMILY WILL:**

Family Processes, risk for altered

Situational crisis

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

Express feelings freely and appropriately.

Direct energies in a purposeful manner to plan for resolution of crisis.

Seek appropriate help.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Determine degree of lifestyle change and extent of financial burden/therapeutic restrictions of pregnancy.

Provides information to identify needs and create plan of care. As more high-risk care is managed in the home setting, including therapy for premature delivery, stressors affecting the family may be greatly magnified.

Encourage verbalization and sharing of feelings.

Helps promote integrity of mutual support system.

Assess verbal/nonverbal cues and negative behaviors, such as inappropriate diet, eating improperly; excessive use of alcohol, tobacco, or tranquilizers; and avoidance of discussion of concerns.

The client who does not appropriately verbalize negative feelings or hostility about the complicated pregnancy may express such feelings with nonverbal cues or behaviors.

Provide 1:1 interaction and support of partner. Promote open communication between partners.

Therapeutic restrictions may result in partner assuming multiple roles, caring for client, trying to manage emotional response and personal concerns for client/fetus with limited coping strategies.

Assess partner for behaviors that negatively affect family process.

Expectant fathers may begin working longer hours, spending increased amounts of time away from home, and abusing alcohol, which are signs of negative coping.

Assess siblings for negative, attention-getting behaviors toward parents or authority figures, such as difficulty in school, truancy, or failure to carry out responsibilities.

Such behaviors may signal anger, jealousy, or resentment of changes in lifestyle necessitated by the complicated pregnancy.

Involve in procedures and decisions regarding therapeutic regimen, when possible.

Provides client/family with some degree of control in what is often viewed as an uncontrollable situation.

Acknowledge strengths, such as client's effective monitoring for diabetes.

Provides positive reinforcement and helps client/couple to view efforts as worthwhile.

Provide anticipatory guidance.

Knowing what is ahead may decrease stress and allow time for adaptation.

Determine availability of resources, e.g., other caregivers, childcare volunteers, others willing to assist with housekeeping/meal preparation.

Adequate support may help client remain in home setting.

Encourage family to verbalize significance of situation if hospitalization is required.

Monitoring/therapeutic interventions are being done more frequently in the home setting; however, separation necessitated by hospitalization of the client may place stress on family members, who may also experience relief or guilt because the healthcare system has relieved them of the burden of care.

Collaborative

Refer to social worker, hospital chaplain, other families in similar situation, and/or community agencies, support groups.

May assist in providing sources of financial/emotional assistance.

Refer for professional counseling, if necessary.

May be needed to maintain family integrity. Family members who are not positively adjusting to a complicated pregnancy may experience a high level of stress and/or negative coping. Such negative coping may result in family disintegration, separation, or divorce.

NURSING DIAGNOSIS:

Therapeutic Regimen: Individual, risk for ineffective management

Risk Factors May Include:

Patient value system, health beliefs/cultural influences, issues of control, presence of anxiety, complexity of therapeutic regimen, economic difficulties, social support deficits, perceived seriousness/susceptibility

Possibly Evidenced By:

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

DESIRED OUTCOMES/EVALUATION CRITERIA—CLIENT WILL:

Participate in the prescribed regimen during pregnancy.

Use appropriate self-care behaviors.

ACTIONS/INTERVENTIONS

RATIONALE

Independent

Identify cause of/contributing factors to perceived lack of cooperation.

The client/couple may find it difficult to follow a prescribed health regimen that significantly alters their lifestyle and requires a great deal of time and energy. In addition, loss of control and anxiety contribute to feelings of helplessness/hopelessness, which increase the possibility of rejection of specific therapeutic interventions. Furthermore, misunderstandings can result in client not following prescribed regimen.

Determine goals that client wants to achieve and the motivating factors.

Full cooperation and commitment are needed to obtain or maintain control of condition.

Review availability and use of resources.

Presence or absence of supportive resources can make the difference for the client and family in being able to manage the situation.

Assist client to reduce/modify causative factors of medical complication. Avoid being judgmental. Encourage an objective problem-solving approach using a cooperative decision-making model.

Gives a sense of control. Pointing out failure often leads to despair.

Discuss and have client demonstrate behaviors/ techniques in question.

During pregnancy, control of condition may require many specific modified or new behaviors. Demonstration allows accurate assessment of learning.

Collaborative

Refer to community resources or to a peer who has had a positive outcome with a complicated pregnancy.

Decreases overwhelming feelings of aloneness; provides role model and opportunity for sharing common experiences. Reinforces idea that efforts can have a positive outcome.