I. Purpose:

To provide safe and standardized nursing care for the patient experiencing a fetal loss.

II. Policy:

Outlines the nursing care of the patient who is experiencing a fetal loss in natural/spontaneous labor, undergoing induction or augmentation of labor.

III. Definitions:

A. Abortion/Termination: the administration to a pregnant woman any medicine, drug or substance, or the use of any instrument, or other means, with the intent to terminate the pregnancy

B. Augmentation of labor: the stimulation of uterine contractions when spontaneous contractions have failed to result in progressive cervical dilation or descent of the fetus.

C. Cervical Ripening: the process of effecting physical softening and distensibility of the cervix in preparation for labor and birth.
D. Induction of labor: the stimulation of uterine contractions before the spontaneous onset of labor for the purpose of accomplishing vaginal birth.

E. Intrauterine Fetal Demise (IUFD) or stillbirth: is defined as a death that occurs in utero after the completion of the 20th week of pregnancy, or the death of a fetus that weighs 350 g or more.

IV. Additional Competencies Required:

Unit-based orientation.

V. Specific Information:

A. Abortion/Termination

Abortion/Termination may be accomplished by the administration of medications to stimulate uterine contractions and cause dilation of the cervix, such as prostaglandin E2 vaginal suppositories, intravenous oxytocin, misoprostol (Cytotec) or prostaglandin cervical application. Laminaria cervical inserts and/or foley bulbs may be used to assist in cervical dilation. Abortion may also be accomplished by manual dilation of the cervix and suction or evacuation of the uterine contents. For safe and standardized care of patients undergoing termination of pregnancy refer to Care of Patients Undergoing Termination of Pregnancy Policy.

B. Labor

For safe and standardized nursing care of the patient in labor refer to policy Nursing Management of the Labor Patient.

C. Admission

1. Admission assessment and documentation is performed in accordance with policy Nursing Management of the Labor Patient.
2. Staff resource for providing emotional/bereavement support – review the Pregnancy Loss and Infant Death Alliance Practice Guidelines 2008
3. Complete the Fetal Loss Bereavement Checklist.

D. Cervical Ripening

1. Cervical Foley Bulb
   a. Obtain 26 Fr Foley catheter with a 30ml balloon/bulb.
   b. Discuss pain control options with patient prior to Foley bulb placement.
c. Assist patient with positioning for placement.
d. Once provider has placed catheter-inflate bulb using 30 to 80 ml of sterile water per provider order.
e. Securing the catheter to the leg and making sure catheter is taut is per provider discretion.
f. BP, pulse and respiratory rate are monitored and recorded hourly or per provider order. Temperature should be obtained on admission and every 4 hours. Increase frequency to every 2 hours if rupture of membranes occurs.

2. Laminaria
a. Obtain ordered size and number of Laminaria from service center, sterile speculum, sponge forceps, exam light and 4X4 gauze.
b. Assist patient with positioning for placement.
c. Once provider has placed Laminaria continue to monitor patient in latent labor. Refer to policy Nursing Management of the Labor Patient.
d. BP, pulse and respiratory rate are monitored and recorded hourly or per provider order. Temperature should be obtained on admission and every four hours. Increase frequency to every two hours if rupture of membranes occurs.

3. Prostaglandin Suppository
a. Vaginal Prostaglandin E2 is placed by the OB provider. Usual Dose: 20mg (keep frozen until use).
b. Assist patient with positioning for placement.
c. Once provider has placed the vaginal suppository, continue to monitor patient in latent labor. Refer to policy Nursing Management of the Labor Patient.
d. BP, pulse and respiratory rate are monitored and recorded every 30 minutes X2 following Prostaglandin insertion. BP, pulse and respiratory rate every 1 hour if stable.

4. Misoprostol (Cyotec)
a. Vaginal Cyotec is placed by the OB provider in the posterior vaginal fornix.
   i. Usual Dose: up to 600mcg per provider order.
   ii. Limit the use of lubricating jelly because it may decrease absorption of the medication.
b. Cyotec may be administered orally or sublingually, per provider order.
c. Additional doses of Cyotec may be given every 6-12 hours as needed, depending on patient response, per provider order.
d. The recommended interval between the last dose of Cyotec and intravenous oxytocin is 4-6 hours.
e. Assessment and documentation of the patient’s vital signs (BP, pulse, and respiratory rate) is completed on admission and every 30 minutes X2 hours following placement of Cytotec. If vital signs are stable prior to and following administration of Cytotec, the assessment and documentation of vital signs may then be done every 4 hours. Temperature is obtained on admission and every 4 hours. Increase frequency to every 2 hours if rupture of membranes occurs.

f. For laboring patients, refer to the policy Nursing Management of the Labor Patient.

g. Activity
   The patient is maintained on bedrest for at least 2 hours following the vaginal Cytotec placement.
   After 2 hours the patient may ambulate as risk status allows.

h. Intake and Output
   -Obtain intravenous access prior to placement of Cytotec by heplock or IV infusion based on patient condition or as ordered.
   -Measure and record hourly and 24 hour intake and output totals.
   -Patients may have clear liquids as risk status allows, per provider order.

E. Induction/Augmentation of Labor with Oxytocin
   1. General procedure for oxytocin administration- Refer to the Guidelines for the Management of Patients Undergoing Induction or Augmentation of Labor policy AS 201111-20.05.
   2. Oxytocin Dosage and Administration
      For standard oxytocin dosing, refer to the Guidelines for the Management of Patients Undergoing Induction of Augmentation of Labor policy AS 201111-20.05.
   3. High dose Oxytocin
      a. Begin Oxytocin infusion at 6mU/min.
      b. Gradually increase Oxytocin by 3-6 mU/min every 30 minutes until adequate progress of labor is established and/or contractions are every 2 to 3 minutes.
      c. Once adequate labor is established, maintain or decrease Oxytocin to baseline rate necessary for continued labor progress. Oxytocin may be increased to a maximum of 20mU/min at the discretion of the nurse. An additional provider order is needed to increase oxytocin infusion beyond 20mU/min.
      d. Maternal assessment
         i. Vital signs
ii. With every increase in oxytocin, and 15 minutes after each titration, assess and document blood pressure, pulse and respiration rate.

iii. When not increasing oxytocin rate, assess and document blood pressure, pulse and respiration rate every 30 minutes if stable.

iv. If membranes are ruptured, assess and document maternal temperature every 2 hours. If membranes are intact, assess and document maternal temperature every 4 hours.

e. Uterine activity

i. Assess and document uterine activity every 15 minutes when actively titrating oxytocin.

ii. Assess and document uterine activity every 30 minutes when maintaining oxytocin dose.

f. Intake and output

i. Obtain intravenous access when beginning oxytocin.

ii. Measure and record hourly and 24 hour intake and output totals.

iii. Patients may have clear liquids as risk status allows, per provider order.

VI. Clinical Implications:

Notify provider for any of the following:

A. Spontaneous rupture of membranes, unsure status of amniotic membranes, or blood stained amniotic fluid;
B. Vaginal bleeding beyond normal bloody show;
C. Analgesia or anesthesia needs of the patient;
D. Vital signs outside parameters of provider orders;
E. Imminent delivery;
F. Significant system assessment findings;
G. Inadequate uterine response at oxytocin dosage of 20 mU/min;
H. Suspected uterine rupture; and/or
I. Deterioration or change in patient condition as outlined in policy Physician Notification for Change in Patient Condition.

VII. Patient/Family Education:

Educate patient/family at the level of their understanding of the following:

A. Plan of care;
B. Pain management options available;
C. Electronic uterine monitoring;
D. Risks and benefits of augmentation/induction procedure; and
E. Room and hospital systems/services.
VIII. Psychosocial Needs:

Coordinate Social Services Consult

IX. Pain Management:

Refer to Pain Management Guidelines policy CL 30-02.04

X. Documentation:

Document the following per protocol above in the patient’s medical record:

A. Admission- refer to policy Nursing Management of the Labor Patient.

B. Ongoing Assessments
   1. Vital signs;
   2. Uterine activity;
   3. Amniotic fluid status;
   4. Cervical exam;
   5. Intake and nutrition;
   6. Output and elimination;
   7. Activity;
   8. Pain management;
   9. Physical reassessment;
   10. Falls risk; and
   11. Medication administration

C. Interventions and maternal response.

D. Document patient and family education in teaching record.

E. Initiate appropriate plan of care pathway and document patient’s progress on the pathway.

F. Complete appropriate forms per Attachment A.

XI. References:


Clinical Policy Manual:
- CL 20-06.08 Physician Notification for Change in Patient Condition
- CL 30-02.04 Pain Management Guidelines
Area Specific Policy Manual: Labor and Delivery
AS 201111-20.03 Nursing Management of the Labor Patient
AS 201111-20-27 Care of Patients Undergoing Termination of Pregnancy
AS 201111-20.05 Induction or Augmentation of Labor


St. Louis: Mosby Elsevier


Washington, D.C.: AWHONN.

Wolters Kluwer/Lippincott Williams & Wilkins.

Templates for Protocols and Procedures for Maternity Services (2nd ed.). Washington,
D.C.: Authors

American Academy of Pediatrics & American College of Obstetricians and

Templates for Protocols and Procedures for Maternity Services (2nd ed.). Washington,
D.C.: Authors.

XII. Endorsement:

OB Patient Care Committee March 19, 2013

XIII. Approval:

Sandy Smith, RN Nurse Manager, Labor and Delivery March 29, 2013

Robin Mutz, RNC, MPPM Administrative Director, Women’s Patient Care Center
March 22, 2013
Guidelines for the Management of Patients Experiencing Fetal Loss
Policy Number AS 201111-20.09

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March 28, 2013