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Placental abruption Initial assessment

Midwifery & O.G. Nursing | Initial assessment

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Fictional educational example. Individualize using verified patient findings, authorized treatment and current local protocols. No real patient record or observed outcome is claimed.

Patient profile and history

31-year-old pregnant woman with suspected abruption. Care stage: At the first supervised assessment.

Medical history: Fictional obstetric history: G2P1 at 34 weeks. New painful bleeding and uterine tenderness raise concern for placental separation. No known drug allergy is reported in this fictional interview; this does not replace medicine-by-medicine verification in real care.

Surgical history: No previous major operation is reported in this fictional interview. Confirm procedure details, complications and any relevant devices when applying the exercise.

Personal and family assessment: The woman requests respectful explanation and involvement of her chosen support person with consent. Assess access to maternity follow-up, nutrition, transport and infant-care support.

Scenario: The patient or caregiver wants to know which concern needs attention first.

Clinical assessment

Subjective: Painful bleeding and abdominal tenderness.

Objective findings and required checks: Uterine pain and possible concealed blood loss; maternal/fetal assessment is urgent.

Physical examination and investigations: Review circulation, blood count, coagulation, blood grouping and fetal assessment; visible bleeding may underestimate loss.

Supply actual values, units, timing and trends during supervised application. Do not invent missing clinical data.

Clinical focus and pathophysiology

Placental abruption: Premature placental separation may cause hemorrhage and reduce fetal oxygen supply.

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Medical / surgical management

Activate emergency maternity care, monitor perfusion and prepare ordered resuscitation and delivery-related care.

Illustrative drug and treatment study

Medicine / treatment	Purpose	Nursing checks
Prescribed fluids/blood products	Support circulation and blood-component needs	Follow the emergency protocol and monitor response
prescribed obstetric medicines	Use for the assessed clinical situation	Verify specialist orders.

Treatment examples are not a prescription. Verify the authorized product, dose, route, timing, contraindications and current local product information.

Nursing process - ADPIE

Assessment

Painful bleeding and abdominal tenderness. Uterine pain and possible concealed blood loss; maternal/fetal assessment is urgent. The patient or caregiver wants to know which concern needs attention first.

Nursing diagnosis

Prioritize bleeding or vulnerability to further blood loss; reduced circulation to vulnerable tissues; pain interfering with rest or activity; learning needs about the condition and care plan. Validate each concern against assessment. For an actual problem, link the problem, contributing factors and observed cues; for a risk problem, document the risk factors without invented symptoms.

Planning

After the first indicated intervention, at the documented review time: document a patient-specific baseline and measurable target. Agree short- and longer-term outcomes with the patient/caregiver; physiological safety takes priority over teaching and discharge tasks.

Implementation

Activate emergency maternity care, monitor perfusion and prepare ordered resuscitation and delivery-related care. Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis. Document care, prescribed treatment, consent and escalation.

Evaluation

Compare reassessment with each stated outcome. Mark met, partly met or not met using observed evidence, document the review time and revise the plan. This vignette provides no completed patient outcome.

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Nursing care plan

Nursing diagnoses use original clinical problem wording. They are not the licensed NANDA-I classification. Verify any formal label or code against your institution's licensed current edition; select actual or risk diagnoses only when supported by assessment.

Context task: Establish the immediate clinical priorities and verify the baseline before assuming a diagnosis.

Set individualized measurable targets and an exact review time. Select actual or risk statements only when supported by assessment.

Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about bleeding, dizziness, bruising and relevant medicines. Assess: Assess blood loss, circulation, consciousness and ordered coagulation or blood counts.	Bleeding or vulnerability to further blood loss. Possible factors: tissue injury, altered coagulation or treatment effects. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Blood loss is recognized promptly and circulation is supported by the emergency or treatment plan. Longer-term: Before the clinically approved transition or agreed follow-up: Identifies bleeding warning signs and medicine-related precautions.	1. Quantify visible loss where possible and escalate active significant bleeding immediately. Rationale: Underestimating blood loss can delay life-saving care. 2. Prepare ordered access, investigations and treatment while monitoring perfusion. Rationale: Coordinated response supports rapid stabilization. 3. Avoid unnecessary traumatic procedures and apply appropriate bleeding precautions. Rationale: Reducing additional injury limits preventable blood loss. 4. Activate emergency maternity care, monitor perfusion and prepare ordered resuscitation and delivery-related care. Rationale: Premature placental separation may cause hemorrhage and reduce fetal oxygen supply. The condition-specific plan addresses the underlying problem while response is monitored.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask about dizziness, chest discomfort, fatigue and cold extremities. Assess: Assess consciousness, pulse, blood pressure, capillary refill and urine trend.	Reduced circulation to vulnerable tissues. Possible factors: altered blood flow or cardiac function. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Circulation and consciousness remain within the clinician-agreed targets. Longer-term: Before the clinically approved transition or agreed follow-up: Describes symptoms that require immediate review and the agreed follow-up plan.	1. Trend perfusion findings and escalate new chest pain, shock or altered consciousness immediately. Rationale: Poor circulation can rapidly threaten organ function. 2. Balance activity and rest and maintain the ordered monitoring schedule. Rationale: Reducing demand supports recovery while trends guide treatment. 3. Administer prescribed therapy and monitor effects and adverse reactions. Rationale: Response monitoring supports safe correction of the underlying problem.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.
Ask: Ask about pain site, onset, severity, quality and the patient's acceptable pain level. Assess: Observe guarding, expression and effect on movement; use an appropriate pain scale.	Pain interfering with rest or activity. Possible factors: tissue irritation, injury or the underlying condition. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Pain decreases toward the patient-agreed target after reassessment. Longer-term: Before the clinically approved transition or agreed follow-up: Uses agreed comfort strategies and explains when new or worsening pain needs review.	1. Assess pain and associated red flags before and after treatment. Rationale: Changing pain may signal a complication and helps evaluate relief. 2. Provide comfortable positioning, reassurance and appropriate non-drug measures. Rationale: Comfort measures can reduce distress and complement prescribed treatment. 3. Give prescribed analgesia and monitor sedation, breathing and other adverse effects. Rationale: Relief should improve function without creating medication-related harm.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
Ask: Ask what the learner already knows and wants to understand. Assess: Use teach-back or demonstration to identify specific gaps.	Learning needs about the condition and care plan. Possible factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Explains the most important immediate action in their own words. Longer-term: Before the clinically approved transition or agreed follow-up: Demonstrates the agreed care skills and names follow-up and warning signs.	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves understanding. 2. Teach a few condition-specific points using plain language and demonstration. Rationale: Focused information is easier to retain and apply. 3. Use teach-back, correct misunderstandings and provide an accessible written plan. Rationale: Checking understanding supports safer self-management. 4. After stabilization explain the event, recovery, follow-up and future-pregnancy review. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	Record the baseline and reassessed finding, the time and whether this goal is met, partly met or not met. If not met, reassess causes and revise or escalate. Do not record an unobserved improvement.

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Health education and continuing care

After stabilization explain the event, recovery, follow-up and future-pregnancy review.

Transition only after clinical readiness is confirmed. Reconcile medicines, check access and caregiver support, and document who will review the patient and when.

Urgent warning signs

Shock, continuous severe pain, coagulopathy signs or fetal compromise is an emergency.

Evaluation and conclusion

For each goal, document met, partly met or not met using observed evidence and the review time. Reassess and revise if progress is inadequate. Individual assessment, prioritized care and coordinated review guide this topic.

Quick Revision

- Premature placental separation may cause hemorrhage and reduce fetal oxygen supply.

- Priority concerns: Bleeding or vulnerability to further blood loss; Reduced circulation to vulnerable tissues; Pain interfering with rest or activity; Learning needs about the condition and care plan.

- Shock, continuous severe pain, coagulopathy signs or fetal compromise is an emergency.

- After stabilization explain the event, recovery, follow-up and future-pregnancy review.

Exam / viva: Which finding changes the order of priorities, and what must be escalated immediately?

References

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