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Placenta previa 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.

Clinical assessment

Subjective: Painless vaginal bleeding and anxiety.

Objective findings and required checks: Bleeding amount and maternal/fetal stability need urgent maternity assessment.

Physical examination and investigations: Review ultrasound diagnosis, blood count, blood-group testing and maternal/fetal assessment.

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

Clinical focus and pathophysiology

Placenta previa: Placental tissue near or covering the cervical opening can cause antenatal bleeding.

Medical / surgical management

Activate the maternity bleeding pathway, monitor losses and prepare prescribed treatment and birth planning; avoid digital vaginal examination until previa is excluded.

Illustrative drug and treatment study

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Medicine / treatment	Purpose	Nursing checks
Prescribed blood products when indicated	Treat significant blood-component loss	Use compatibility and reaction-monitoring procedures
pregnancy-specific medicines when ordered	Support the specialist plan	Verify indication and timing.

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

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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 the maternity bleeding pathway, monitor losses and prepare prescribed treatment and birth planning; avoid digital vaginal examination until previa is excluded. Rationale: Placental tissue near or covering the cervical opening can cause antenatal bleeding. 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 what worries the patient most and how they prefer to receive information. Assess: Observe distress, attention and ability to engage without making assumptions.	Emotional distress affecting participation in care. Possible factors: uncertainty, symptoms or unfamiliar treatment. Validate against the patient's assessment.	Short-term: After the first indicated intervention, at the documented review time: Identifies one immediate concern and participates in an agreed next step. Longer-term: Before the clinically approved transition or agreed follow-up: Describes helpful support and coping strategies before transition of care.	1. Listen without judgment and acknowledge specific concerns. Rationale: Feeling heard supports trust and therapeutic engagement. 2. Explain one step at a time and use teach-back with permission. Rationale: Manageable information reduces uncertainty and checks understanding. 3. Offer culturally appropriate support and refer when distress persists or safety concerns arise. Rationale: Additional support may be needed beyond bedside reassurance.	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 what the learner already knows and wants to	Learning needs about the condition and care plan. Possible	Short-term: After the first indicated intervention, at the	1. Assess language, literacy, hearing, vision and preferred learning method. Rationale: Accessible teaching improves	Record the baseline and reassessed

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Assessment: subjective / objective	Nursing diagnosis: original problem wording	Short- and longer-term goals	Nursing interventions with rationale	Evaluation
understand. Assess: Use teach-back or demonstration to identify specific gaps.	factors: new information, complex treatment or limited prior teaching. Validate against the patient's assessment.	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.	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. Explain bleeding precautions, when to seek urgent care and the individualized delivery plan. Rationale: Condition-specific teaching connects the treatment plan to safe continuing care.	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

Explain bleeding precautions, when to seek urgent care and the individualized delivery plan.

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

Heavy bleeding, shock, uterine pain or fetal concerns requires immediate emergency maternity care.

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

- Placental tissue near or covering the cervical opening can cause antenatal bleeding.

- Priority concerns: Bleeding or vulnerability to further blood loss; Reduced circulation to vulnerable tissues; Emotional distress affecting participation in care; Learning needs about the condition and care plan.

- Heavy bleeding, shock, uterine pain or fetal concerns requires immediate emergency maternity care.

- Explain bleeding precautions, when to seek urgent care and the individualized delivery plan.

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

References

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https://www.indiannursingcouncil.org/gazette-notification

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