**Vital Sign Management Guidelines for**

**Post-Administration of IV Antihypertensive**

1. Post IV antihypertensive BP management
   1. Monitor VS
      1. q 15min X 1 hour
      2. q 30 min X 1hour
      3. q hour x 4 hours
   2. Admissions to ASCU, PP, or Women’s Gyn from Triage/L&D/L&D OR-hold patient for 30 minutes once threshold is met
      1. 1st stable BP no sooner than 15 minutes post Labetalol
      2. 1st stable BP no sooner than 15 minutes post hydralazine
   3. Patients admitted to L&D, L&D OR, PCU, or WICU may transfer and continue VS per protocol
2. Patients requiring ≥ 3 doses of IV antihypertensive or the BP does not meet threshold by 1 hour should be admitted to L&D, PCU, or WICU.
3. Patients admitted due to preeclampsia with any of the severe features listed below should be admitted to L&D, PCU, or WICU.
   1. Increasing BP
   2. Headache unrelieved with medication
   3. Visual changes – blurred vision, floaters, spots, blind spot
   4. Altered LOC- agitation, restless, lethargy, hallucinations
   5. Upper abdominal pain
   6. Urine output <30 ml/hr
   7. SOB
   8. Chest pain
   9. SaO2 <95%
   10. Cough
4. Rapid Response should be notified of any patient requiring the OB Hypertensive Emergency Protocol.

References:

Chagolla, B., Berg, O., Gabel, L. (2013). Ante, intra, postpartum nursing management and assessment of preeclampsia: maternal/fetal assessment and monitoring recommendations. Retrieved on 2/1/2016 from <https://www.cmqcc.org/resource/ante-intra-postpartum-nursing-management-and-assessment-preeclampsia-maternalfetal-0>

Committee on Obstetric Practice. (2015). Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period. *American College of Obstetricians and Gynecologists*.