Nursing Acuity Assessment

Assess: Daily weights, medication schedule, physical assessment, mental status, B/P and trends, and hourly intake and output

GREEN ZONE: All Clear	**S/S and Labs**	**ACTION**
• Patient is thinking clearly • Patient is seeing clearly • Patient is breathing clearly 	• No headache • Not dizzy • Can do usual activities • No pain in belly or pelvis • Baby is moving normally • Urinating 50 ml or more per hour • Plt >100, AST up to twice upper limit of normal value, creatinine less than 1.1	**Green Zone: Patient is doing well** • Patient plan of care is working • Administer hypertensive agent as prescribed • Follow doctors' orders

YELLOW ZONE: Caution	**S/S and Labs**	**YELLOW ZONE: WARNING, INCREASE SURVELLIANCE**
• Patient is not thinking clearly • Patient has blurry or impaired vision • Patient is not breathing clearly • Patient has a mild HA • Patient feels dizzy • Patient is abnormally drowsy	• Patient is anxious or upset • Altered mental status • Patient has nausea and vomiting • Patient has chest, belly, or pelvic pain • Urinating less than 30-49 ml per hour • Plt 50-100, AST> twice upper limit of normal • Creatinine 1.1 or greater; or more than twice the serum creatinine in the absence of renal disease • BP 140/90-159/109; Heart rate is 111-129 • Category II Fetal tracing	• Perform physical assessment • Monitor B/P and HR per policy • Contact charge nurse, primary doctor, anesthesia, and newborn resuscitation team 

RED ZONE: IMMEDIATE ATTENTION	**S/S and Labs**	**RED ZONE: EMERGENCY, GET HELP! CALL RAPID RESPONSE**
• Patient unresponsive • Ongoing, unrelieved headache • Temporary blindness • Decrease in respiration (<12) 	• Ongoing nausea and vomiting • Patient has chest, abdominal, or pelvic pain • Urinating less than 30ml in 2 hours • Plt <50, AST to twice upper limit of normal and creatinine >1.1 or more than twice serum Creatinine Blood pressure • SBP≥160 or DBP≥ 110 (Hypertensive Emergency State if B/P remains elevated for 15 minutes • Depressed patellar reflexes • Category III Fetal tracing	• Evaluate patient immediately • 1:1 ratio; Mag Sulfate infusion • Consider Neurology consult, CT Scan to R/O intracranial hemorrhage • Initiate HTN medication panel in 30 minutes • Apply Supplemental O2 w/ nonrebreather • R/O Pulmonary edema • Contact charge RN, primary doctor, anesthesia, newborn resuscitation team immediately