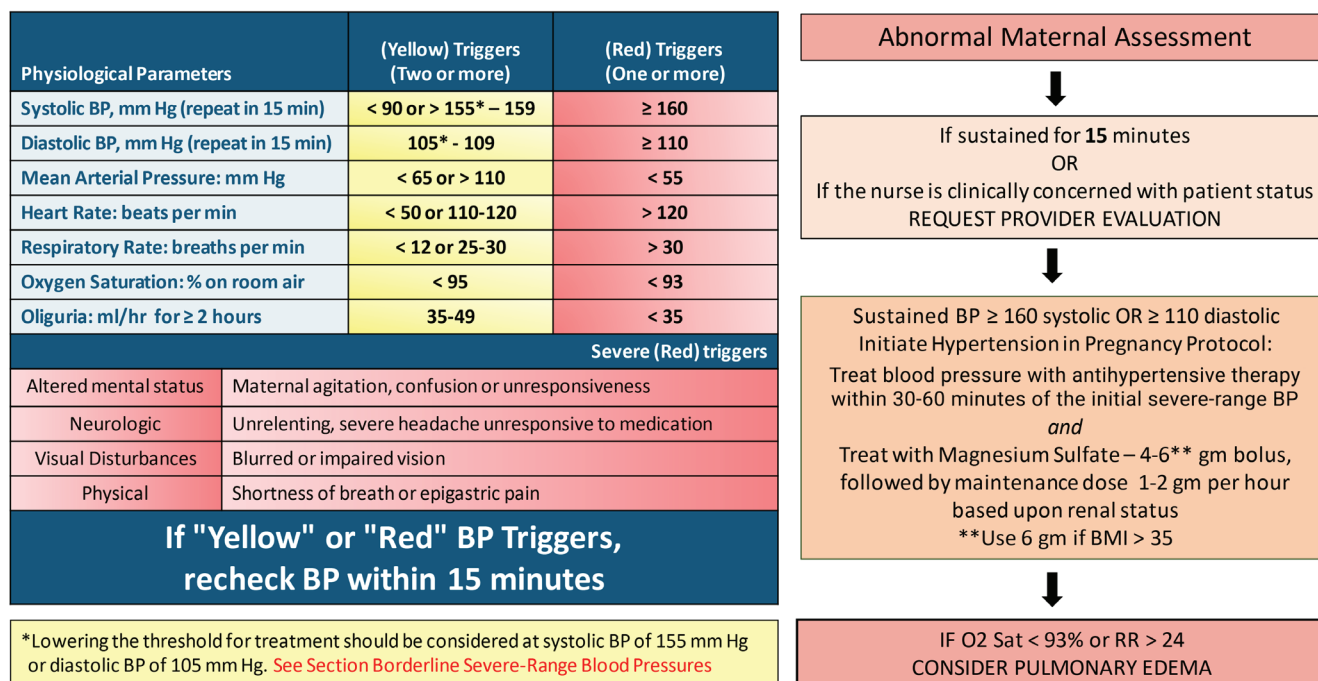


Appendix D: Preeclampsia Screening Tools

A. Preeclampsia Early Recognition Tool integrated within a Maternal Early Warning System



This figure was adapted from the Improving Health Care Response to Preeclampsia: A California Quality Improvement Toolkit, funded by the California Department of Public Health, 2014; supported by Title V funds.

B. Preeclampsia Early Recognition Tool (PERT), page 1 of 2

ASSESS	NORMAL (GREEN)	WORRISOME (YELLOW)	SEVERE (RED)
Awareness	Alert/oriented	▶ Agitated/confused ▶ Drowsy ▶ Difficulty speaking	Unresponsive
Headache	None	▶ Mild headache ▶ Nausea, vomiting	Unrelieved headache
Vision	None	Blurred or impaired	Temporary blindness
Systolic BP (mm Hg)	100-139	≥ 155-159	≥ 160
Diastolic BP (mm Hg)	50-89	90-109	≥ 110
HR	61-110	110-120	> 120
Respiration	11-24	< 12 or 25-30	< 10 or > 30
SOB	Absent	Present	Present
O2 Sat (%)	≥ 95	< 95	< 93
Pain: Abdomen or Chest	None	▶ Nausea, vomiting ▶ Chest pain ▶ Abdominal pain	▶ Nausea, vomiting ▶ Chest pain ▶ Abdominal pain
Fetal Signs	▶ Category I ▶ Reactive NS	▶ Category II ▶ IUGR ▶ Non-reactive NST	Category III
Urine Output (ml/hr)	≥50	35-49	≤ 35 (in 2 hrs)
Proteinuria*	Trace	▶ ≥ +1** ▶ ≥ 300mg/24 hours	Protein/Creatinine Ratio (PCR) > 0.3 Dipstick ≥ 2+
Platelets	>100	50-100	< 50
AST/ALT	< 70	> 70	> 70
Creatinine	≤ 0.8	0.9-1.1	≥ 1.1
Magnesium Sulfate Toxicity	▶ DTR +1 ▶ Respiration 16-20	Depression of patellar reflexes	Respiration < 12

B. Preeclampsia Early Recognition Tool (PERT), page 2 of 2

*Level of proteinuria is not an accurate predictor of pregnancy outcome

GREEN=NORMAL: proceed with caution

YELLOW=WORRISOME: Increase assessment frequency

1 Trigger, TO DO:

Notify provider

≥ 2 Triggers, TO DO:

- ▶ Notify charge RN
- ▶ In-person evaluation
- ▶ Order labs/test
- ▶ Anesthesia consult
- ▶ Consider magnesium sulfate
- ▶ Supplemental oxygen

**Provider should be made aware of worsening or new-onset proteinuria

RED=SEVERE: Trigger, 1 of any type listed below

1 of any type:

- ▶ Immediate evaluation
- ▶ Transfer to higher acuity level
- ▶ 1:1 staff ratio

Awareness, Headache, Visual

- ▶ Consider Neurology consult
- ▶ CT Scan
- ▶ R/O SAH/intracranial hemorrhage

BP

- ▶ Labetalol/Hydralazine/nifedipine within 30-60 min
- ▶ In-person evaluation
- ▶ Magnesium sulfate loading or maintenance infusion

Chest Pain

- ▶ Consider CT angiogram

Respiration SOB

- ▶ O2 at 10L per non-rebreather mask

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