POLICY:

1. To provide safe nursing care during and after the amniocentesis. Amniocentesis is performed in Labor & Delivery to assess fetal lung maturity, establish rupture of membranes, rule out infection, evaluate fetal well-bring or evaluate for chromosomal abnormalities.
2. All pregnant patients with potentially viable fetus' who require amniocentesis will be performed on the Labor and Delivery unit. A minimum tracing of 20 minutes before and 30-60 minutes after the amniocentesis will be obtained to establish fetal and uterine status. RH status will be determined before amniocentesis procedure. All patients will have IV access prior to procedure.

EQUIPMENT:

1. Amniocentesis kit
2. #20 or #22 gauge
3. 5 or 6 inch spinal needle 3 Lidocaine 1% (optional)
4. Ice if for L/S ratio
5. Laboratory requisition form
6. Electronic Fetal Monitor
7. *If amniocentesis is to rule out spontaneous rupture of membranes (SROM) add:
   a) Indigo Carmine
   b) #20 or #22 gauge needle
   c) 12 cc syringe
   d) Tampon
   *If amniocentesis is for twins add:
   a) Additional spinal needle
   b) Indigo Carmine
   c) #20 or #22 gauge needle
   d) 12 cc syringe
   *If amniocentesis is for genetics add:
   a) Two or more plastic centrifuge tubes with orange plug seal caps
   b) A copy of the patient's insurance card or 'face sheet' with insurance information on it. Send to lab with requisition.

DOCUMENTATION:

1. Fetal heart rate (FHR) baseline and uterine activity (UA) baseline should be documented both before and after the procedure on the appropriate flow sheet.
2. Document time of procedure on appropriate flow sheet.

PROCEDURE:

1. Explain procedure to patient. Give support as needed.
2. Positions patient in low Fowlers or dorsal recumbent position with hip roll.
3. Place the patient on the fetal monitor.
4. Obtain maternal vital signs and IV access. If Rh status unknown obtain type and screen.
5. Before beginning the procedure a "time out" will be called.
6. When ready, remove the fetal monitor and assist the physician as needed with the procedure.
7. Label the specimens with patient's T00# and the patient's name.
8. Re-apply the fetal monitor after the procedure to document FHR and UA post- procedure.
9. To rule out SROM, place a tampon in the vagina after the procedure. Encourage ambulation after completion of fetal monitoring. Remove tampon after a minimum of two hours. Inspect for color change.
10. Enter order for amniocentesis; lab labels will generate.
    a) For L/S ratio place specimen in a red top tube, place on ice and transfer to lab.
    b) For Delta O/D 450 place in red top tube and immediately wrap tube in aluminum foil from amnio kit.

c) For genetics specimens, no ice is required. A minimum of 25 cc of amniotic fluid is required. Transfer the fluid from the syringes into the centri-fuge tubes (with orange plug seal caps). Label the tubes with the sticker going lengthwise taking care not to cover the numbers on the tube. Send the fluid to central processing (same as for all lab specimens). *Fill out a cytogenetics requisition form. *In the “Indication for Test” area under “Additional Clinical Information”, please note if there is an intrauterine fetal demise (IUFD) / if the patient had an amnioinfusion / if labor is being induced / or any other relevant clinical information.Give Rhogam if indicated before patient

11. Discharge instruction Sheet must be is discharged
12. Provide post amniocentesis discharge instruction

EMPHASIS:

1. Written consent must be obtained by MD.
2. A minimum tracing of 20 minutes before the procedure should be obtained to establish fetal and uterine status.
3. Document “time out” check was completed.
4. A tracing of 30-60 minutes should be recorded following amniocentesis to establish fetal.
5. Include the gestational age and diagnosis, T00#, attending physician and reason for testing. a) Fluid must be send to lab by 11:00 A.M. if an L/S ratio result is to be completed by that evening. b) Bilirubin in amniotic fluid breaks down if exposed to light. c) If the specimen is bloody a FISH cannot be done because of maternal cell contaminations.