Student Name: Madeline Naylor Unit: SIM Pt. Initials: _____ Date: _____

Medication Worksheet – Current Medications & PRN for Last 24 Hours

Primary IV Fluid and Infusion Rate (ml/hr)	Circle IVF Type	Rationale for IVF	Lab Values to Assess Related to IVF	Contraindications/Complications
	Isotonic/ Hypotonic/ Hypertonic			

Generic Name	Pharmacologic Classification	Therapeutic Reason	Dose, Route & Schedule	Correct Dose? If not, what is correct dose?	IVP – List solution to dilute and rate to push. IVPB – List mL/hr and time to give	Adverse Effects	Appropriate Nursing Assessment, Teaching, Interventions (Precautions/Contraindications, Etc.)
Oxytocin	Labor Inducer	Inducing Labor Prevents Hem.		Y N		uterine rupture abruptio placentae, HTN, SIADH	1. B.B.W.: not for elective labor induction 2. EFM when given 3. Contra: if vag delivery contraindicated 4. Contra: inadequate contraction progress
Magnesium Sulfate	Labor Suppry/ Tocolytic	↓uterine contractions, seizure		Y N		CV collapse Resp. paralysis hypothermia pulm. edema	1. Contra: Myocardial Damage/block 2. Moniter Cr. & baseline 3. Monitor patellar reflex prior to dose 4. Contra: diabetic coma
Meperidine	opiod	pain, pre-op., shivering post-op		Y N		resp depression, apnea, cardiarrest shock, ↓HR, seizure	1. B.B.W.: Addiction/Abuse 2. B.B.W.: Respiratory Depression 3. Teach: do not mix w/ ETOH/other drugs 4. Contra: MAOI w/in 14days
Promethazine	Antiemetic	allergic condition, N/V, sedation urticaria		Y N		tissue damage, apnea, resp. depres, hallucination, extrapyramidal SX, ↓HR,	1. B.B.W: severe tissue injury if extravasate 2. B.B.W: Respiratory Depression 3. Contra: comatose pt., SC inj., Reye syn. 4. Monitor CBC + ophthalmic exam
Calcium Gluconate	Antidotes	hypocalcemia, hypermagnesia, osteoporosis prevention		Y N		hypercalcemia, nephrolithiasis, syncope	1. Contra: hypercalcemia/ hypophosphatemia 2. Contra: digitalis toxicity/vent. fib (IV) 3. Monitor Ca + ECG 4. Toxic w/ prolonged use if renal impair

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Phytonadione	Coagulation Factors	hypoprothrombinemia		Y N		anaphylaxis, anticoagulation resistance	2. B.B.W.: Severe rxn (Anaphylaxis) 2. Contra: over anticoagulation 3. toxicity if renal impairment 4. Teach they may have taste changes
Erythromycin Ophthalmic Ointment	Antibacterial	ocular infections		Y N		N/A	1. No Contraindications 2. Common Rxn: ocular irritation 3. Common Rxn: erythema 4. get consent from mom?
Engerix B	Vaccine	immunization of Hep-B		Y N		neurotoxicity, seizure, shingles, meningitis, ↓BP, erythema nodosum	1. Contra: hypersensitive to yeast 2. Contra: latex allergy + prefilled syringe 3. Caution if immunocomp/ >60 y/o 4. May get during pregnancy
Hepatitis B Immune Globulin		Hep. B inf. prophylaxis & prevention		Y N		anaphylaxis, thromboembolism (IV) viral transmission risk	1. Contra: IV Admin post exposure 2. Caution IgA deficiency 3. Caution pt >60 y/o 4. May get during pregnancy
				Y N			1. 2. 3. 4.

CASE STUDY - INDUCTION OF LABOR

A G3, P2 patient at 41 weeks gestation is admitted for induction of labor. Assessment data reveals: cervix dilated 2 cm, 40% effaced, -2 station, cervix firm, and membranes intact. The patient's last baby was delivered at 40 weeks and weighed 9 pounds. The physician has ordered Prostaglandin administration the evening before Oxytocin in the morning.

1. What is the indication for induction of labor?

   She is already at 41w gestation and only 2cm dilated, to prevent PROM/SROM and possible infection or a post-term baby, being induced is the best option

2. Why did the physician order prostaglandins the evening before the induction?

   The cervix is not fully ripened so by giving prostaglandins it helps open the cervix before giving Oxytocin (which prompts contractions)

3. What tests or evaluation should be performed prior to the induction?

   - Leopolds Manuever to assess if need for C-section
   - EFM
   - May do vaginal exam

4. What are the nursing considerations when administering an Oxytocin infusion?

   - monitoring contractions/EFM
   - ensure no contrainaications & correct dosing

CASE STUDY - Diabetes in Pregnancy

A 30-year-old, G2, P1, is in her 10th week of pregnancy. Her first baby was stillborn at 32 weeks, so she is very worried about this pregnancy. Initial lab work obtained two weeks ago included testing for diabetes, due to the patient's history a stillborn. The physician explains during the first prenatal visit there is a concern for diabetes due to an elevated glucose level. The nurse realizes patient education regarding diabetes, the effects of diabetes on both the patient and baby and how to manage diabetes it is essential.

1. Discuss maternal risks associated with diabetes and pregnancy.

   Mothers can experience preeclampsia, preterm labor, ↑ morbidity. Additionally the mother can have worsening retinopathy, DKA, and hypoglycemia.

2. Discuss fetal-neonatal risks associated with diabetes and pregnancy.

   The fetus can be stillborn or born prematurely. It may also have jaundice or Large birth weight.

3. What educational topics should be covered to assist the patient in managing her diabetes?

   - Medication Education
   - How to check blood sugars/what they mean
   - Nutritional/Exercise changes
   - Follow ups
   - No pedicures

4. What classification (SGA, AGA, LGA) will this patient's baby most likely be classified as? Discuss your answer.

   LGA because of the higher than normal glucose in the body. The pancreas makes extra insulin and this gives the baby more energy which is converted into fat.

CASE STUDY - Pregnancy Induced Hypertension

A single 17-year-old patient Gr 1 Pr 0 at 34 weeks gestation comes to the physician's office for her regular prenatal visit. The patient's assessment reveals BP 160/110, DTR's are 3+ with 2 beats clonus, weight gain of 5 pounds, 3+ pitting edema, facial edema, severe headache, blurred vision, and 3 + proteinuria.

Patient's history – single, lives with her parents, attending high school, works at local grocery store in the evenings as a cashier, began prenatal care at 18 weeks, has missed two of her regularly scheduled appointments for prenatal care, never eats breakfast, snacks for lunch and eats dinner after she gets off work at 10:00 pm.

1. What disease process is this patient exhibiting? What in the assessment supports your concern? Severe Preeclampsia. Her BP, proteinuria +3, extensive edema and hyperflexia w/ clonus support this.

2. What in the patient's history places her at risk for Pregnancy-Induced Hypertension?
   She is 17 y/o ~~and began prenatal~~

3. Describe how Pregnancy-Induced Hypertension affects each organ and how these effects are manifested.
   Cardiorespiratory: HTN, ARDS, pulmonary edema, CV dysfunction, edema
   CNS: eclampsia, CVA, PRES, coma
   Renal: proteinuria, ~~AKN~~ AKI, ATN
   Hepatic: inflammation, dysfunction/rupture/failure/hematoma
   Blood: thrombocytopenia, DIC

4. What will the patient's treatment consist of?
   - Antihypertensive meds
   - Magnesium sulfate (4 seizures)
   - ensure calcium gluconate nearby
   - monitor B/P

5. What is the drug of choice for this condition? What other medication(s) might be ordered for this patient? - Labetalol / Hydralazine
   ~~Zaba~~ Magnesium Sulfate ☆
   - calcium gluconate

6. What are the Nursing considerations when administering the drug of choice? (Side effects & medication administration guidelines)
   - Monitor HR + BP q15min
   - have inj. Calcium Gluconate available to reverse paralysis